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ABSTRACT

This theme newsletter issue presents seven articles describing toddler behavior and development, services for toddlers, and toddlers with special needs. The first article, "Toddlers: Themes and Variations" (Lois Barclay Murphy and Colleen Small) focuses on variations in toddler development, noting emerging skills, language, and the caregiver role. Nina Wallerstein, in "Observations of an Active Toddler," details the activities of one toddler over a typical 45-minute period. "Attachment and Exploration: The Toddler's Dilemma" (Alicia F. Lieberman), considers the toddler's task of balancing between the need for a secure base and his developmental urge to explore and experiment. Abbey Griffin, in "State Regulations Concerning Toddlers in Child Care," reviews and compares relevant state standards. Opportunities for social development in a mixed-age mixed-ability program are described by Nancy Balaban in "Mainstreamed, Mixed-age Groups of Infants and Toddlers at the Bank Street Family Center." Seven phases in the transition to out-of-home care for toddlers with special needs is discussed by Tess Bennett and others in "The Transition Process for Toddlers with Special Needs and Their Families." An article by Sarah Landy and Ray DeV. Peters titled "Understanding and Treating the Hyperaggressive Toddler" describes cases of toddlers with aggressive conduct problems, considers the regulation of affect in toddlers, identifies components of the growth-promoting environment as well as the "circle of rejection," and proposes a model for treating aggressive toddlers and their parents. (DB)

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Toddlers: Themes and Variations

by
Lois Barclay Murphy
Colleen Small

"Toddlers" is our term for little children who have outgrown dependence upon being carried but have not yet reached well-coordinated, secure walking. On any day in the Washington Zoo I see scores of them: some are scampering ahead of a watchful father, mother or caregiver; others are proudly pushing their strollers ahead of them until they get tired and decide to ride; still others are up on their fathers' shoulders or, more rarely, in a pack on mother's back. There are amazing individual differences in the patterns followed by children as they move toward independent locomotion—perhaps the most dramatic transition stage of all child development.

The anthropologist Margaret Mead often remarked that "eight-year-old boys are the same around the world." We cannot say that this is true of children at the toddler stage. Biologically, of course, they go through the same sequences of motor development and the growth of other capacities. But how these capacities emerge and are used is influenced by expectations and pressures typical of the individual culture; the child's own interests; and the responses of parents and caregivers.

In this essay, I encourage readers to take a close look at very young children as they develop locomotion. Observing toddlers in natural situations reveals the complex interrelationship among various lines of development in any one child. Watching young children in their everyday environments also teaches us that for the toddler free to explore it, the ordinary world

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is unspoiled—full of sources of learning about the world's satisfactions, dangers, potentialities for creating, and opportunities for achievement. Laboratory studies are important for refining observations and testing hypotheses, but they do not give us the spontaneous responses that we glimpse in natural situations: the toddler who pulls over a chair to climb on in order to get up on the kitchen table and play with the six-pack of ginger ale bottles. We cannot foresee what will arouse the curiosity or interest of a particular two-year-old—we can only watch and take note. (The record by Nina Wallerstein on page 5 suggests the richness to be gleaned from even brief observations of toddler exploration).

By emphasizing the variations in development among toddlers, I also hope to convey the importance of individualizing their care. At home or in group care settings, toddlers need time and one-to-one communication with parents and caregivers, so that a day-by-day partnership can evolve. As I observe toddlers and adults at the Zoo, I am pained to discover that perhaps only one in ten parents discusses with children what they see. Such missed opportunities result in a loss for the adult as well as for the child. For the toddler's remark, "See the elephant's two tails!" not only reveals the child's unique perception of reality, but also stimulates the adult to see the world as "wonder-ful" once again.

Getting around

In the latter half of the first year, babies try to get around, and do this in different ways. Some babies go on all fours—that is, on hands and knees with eyes looking up--and develop considerable speed. Others creep prone on the floor, going more slowly. Still others develop what I call a "sit-and-go" technique, sitting with one leg extended and hunching along. This method permits a better view of the world than any crawling or creeping position, and implies the child's strong interest in what she can see. (I use the female pronoun here because I have seen this technique used by little girls more often than I have seen it with boys. It would be interesting to study the sequelae of these differences in order to see whether the "sitters" remain more intensely visually oriented than the crawlers and creepers.)

The development of the capacity to get around occurs as young children are also gaining skill in poking, grabbing, pulling, banging together, and dropping objects. Observing the interplay between the child's interest and the growth of coordination is fascinating.

• At a party for toddlers, I saw one 8-month-old youngster running around the room with perfect ease, while his host had not yet begun to try to walk at the age of 13 months (and would not do so until 18 months). The bodies of the two children were very different. The 8-month-old was slender and beautifully coordinated; he had no problem in coping with his weight. In contrast, his host was heavy, with a low center of gravity, and it was not easy for him to stand up. However, he had beautiful fine muscle coordination and could thumb the pages of a magazine like a grown-up.

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• The baby lying in a carriage sees trees and reaches for sunbeams filtering through the branches. The toddler, exploring the world from a vertical position, now responds particularly to objects at his own eye level—wheels of vehicles, fire plugs, packages on grocery shelves. (Closeness to the ground is also used by some toddlers as an expression of assertiveness; they sit or lie down, firmly resisting being lifted or moved, screaming at the top of their voices.)

• *All* of a toddler's new capacities invite experiment—spitting, biting, throwing and smearing offer interesting new sensations and multiple occasions for delight in experiences that adults do not consider so delightful. Sometimes adults are distressed even when the exercise of manual skill by a toddler does not involve dirt or destruction. For example, some children are "feelers"—that is, they love to dribble sand through their fingers, feeling the texture. The mother may bring pails or toys, hoping that Jennifer will "do" something with the sand. But Jennifer's interest in the *feeling* of the sand may be the first step in getting acquainted with the qualities of materials, which will be useful thirty years later when she has become an architect.

LOIS BARCLAY MURPHY

Emerging **skills**

We sometimes forget that the very word "toddler" recognizes that skill in walking improves only gradually. Secure walking may not be reached until after a child is two years old. In this transition stage, maturation of coordination and balance differs from child to child and influences the functioning of locomotion.

A little girl who, I hope, will become a Senator, walks erect with the dignity of a Barbara Jordan, while some of her agemates really do toddle, with uncertain equilibrium. Toddlers vary not only in their walking skills and endurance, but also in their feelings about a fall. Some of them quickly get up and run along as if a fall was nothing to worry about; others, with, doubtless, a lower threshold for pain and feelings of frustration, seem to feel frightened or disappointed that their pride in the new achievement has not proved safe. A reassuring cuddle and suggestion that "You'll feel better soon," may help to prevent a residue of insecurity from persisting when the child who fell down is upset.

Toddlers want to get down and run, dashing ahead of the adult, exulting in freedom, or pulling her along as if bored with the slow pace of grown-ups. But toddlers get tired quickly, and do not have much endurance. (Yet even in their strollers, toddlers are more flexible than older children; we see them turning at the shoulder to look to one side, stretching their necks to see as far behind them or above them, as well as down.)

Of course, some of the children who would be called toddlers in this country might be more appropriately called "riders" in their own cultures. In India, Africa and other parts of the world, children between one and two years of age are often being carried on the hips of their mothers or older siblings. There is less cultural pressure to stand and walk as early as possible. There are differences from city to countryside as well. Of course, "riders," like "toddlers," are exploring their environment, but through vision rather than locomotion. The sensitively detailed drawings of very young children from these cultures may reflect the intensity of their early visual experiences.

Toddlers are just beginning to develop a number of other skills, besides walking. They differ widely in their ability to feed themselves, use the toilet, and dress themselves. (Some toddlers can pull off sweaters and jackets, but at this stage it is rare for a child to be able to put on any clothes except mittens.) It is important to remember how much individual attention and patience are required to help a very young child achieve these skills. A toddler needs to be dressed slowly and gently, with explanations about exactly what is being done. If she is dressed hastily or roughly, the dressing process is not a happy experience that invites effort. Teaching toddlers to use the toilet requires even more

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attention to individual differences. Some toddlers like to watch the flushing water go down the drain; others need reassurance that they could not possibly disappear like their bowel movements, that it is safe to go to the toilet.

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As toddlers do achieve a goal, whether it is walking, putting on a mitten, or finding a lovely dandelion, they may express their pride in what Charlotte Buhler called a "triumphierende blick"—a triumphant glance. Excitement and happy surprise may also be expressed in an ejaculation: "Eek!"

Language as a clue to the mental and emotional life of toddlers

Coordination of the muscles involved in speech does not guarantee progress in language. The child's interest in communication and the responses he receives from the environment also play a part. Some very young children are in love with words and names of things, asking "What's dis?" while pointing in sequence to the edge of a table, to its top, and to its leg. Some children begin to talk before they understand that words have meanings. One child, having heard the word "No" frequently, used it in varying contexts as a "representative word" to mean "yes," "no," and many other things. As children begin to talk, sometimes we can observe the unique way in which they perceive an object. Not quite two, but with an impressive vocabulary, Al looked at a toy dinosaur constructed of wooden units which could be moved to make a mobile long neck and tail. "Two handles," he exclaimed, as he moved the neck and tail up and down.

When we use language in an effort to reassure toddlers, we need to remember that the child of 18 months does not yet understand when mother promises that she will come back "later" or "this afternoon." Specific times like "after nap" or "at lunch time" can give the child a handle on time ideas.

Caregivers and toddlers

Not unlike adults, toddlers tend to follow the line of least resistance, to use their strengths. Since toddlers differ so widely, they need help from parents and caregivers to balance their skills so that they can use the environment more fully. The agile child who is not talking will need a caregiver's help in communication; the child who is talking but not yet walking may need help to develop confidence in taking the first step. At the same time, individual differences should be respected. It is a mistake, for example, to characterize a quiet child whose eyes are busily observing her surroundings as "lazy." Actually, such children are often more creatively productive than children who actively explore cupboards, fences and steps from an early age. In longitudinal studies we find some quiet children becoming active at a later stage. The early quiet period was a time for orientation.

What is most important is the development of a partnership between the toddler and the adult. Good teachers bring things for the toddler to explore and respond to, then share as a partner with the child. Toddlers' anxieties about separation from parents make close, warm, loving support from other caregivers especially important. No one teacher can give more than three or four toddlers the practical assistance, encouragement of exploration, and emotional comfort that each one needs.

LOIS BARCLAY MURPHY

In conclusion

The transition period we call toddlerhood is emotionally, mentally, and physically complex. Even within a small group of children in the same culture, the variety of patterns of developmental change is impressive. The individuality of toddlers and the incompleteness of their achievements call for enduring, responsive, and intimate one-to-one relationships with parents and caregivers. It is in the context of loving relationships that true autonomy unfolds.

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Nina Wallerstein's observations of her active toddler
November 10, 1990 (Alexei is 19 months old):

Alexei has just started eating Cheerios and milk. He's very careful lifting up the spoon to his mouth. He doesn t like to have the Cheerios fall off the spoon. He pushes them in his mouth and picks up the ones which fall onto his bib ...

He likes to do things *himself* now—pulling the plate to his chest, yelling no when I try to help him ...

LOIS BARCLAY MURPHY

Alexei and I are sitting Saturday morning listening to his dad's folk music show on the radio. I was trying to feed him with another spoon also and he grabbed it from me. Now he's got two, getting milk all over.

Done eating, starting to play putting the spoons in the various dishes and pretending to eat, though he knows nothing's there. He says, "Ya (Spanish for 'enough'; Alexei's caregiver is Spanish-speaking)—all gone" and flips his hands back and forth in a gesture of "enough."

I bring him more Cheerios—he places them on a spoon and raises it carefully, then gets fed up and he stuffs some in his mouth ...

Oh,oh—he wants down, wants his hand clean, wants to keep hold of the towel, gets down and runs across the room to his toy box. Stops where the fire was last night, points and says "fire," grabs a sack of wood and drags it over to me, finds the cord of a windowshade hanging, says "hi' and puts it up against his cheek, then discovers the end is shaped like a bell. He puts it up to his mouth and is saying "toot toot" and dancing around, turning around making himself dizzy, and just laughing as he extends the cord, now back to "toot toot."

Now he's running back and forth, laughing, until he reaches the end of the cord. He squeals as he turns around; he lets go and runs and grabs it again.

He slips and falls ... comes to me for comfort to rub his hands, but bounces right back ... making all kinds of noises: "Ahhh, toot toot, let's go, no, no, no." Falls down and becomes a puppy, crawling around. Now he's a kitty, "meow, meow." (It's only a few days since he first started pretending he's an animal.)

Ran over to the window, discovered a clothes brush, which he started wiping against a chair ... but turned it into a "bang bang" extension of his arm, banging the air, and laughing, saying, "bang bang." Oh—coming close; starts banging me. I say, "Honey, don't bang bang Mommy," but he laughs, so I tell him to go bang the chair. He runs over and bangs the chair, picks up a spoon and bangs it and the brush together, swings his arms back and forth, dancing and banging to the music, runs around the room, back to the "toot toot" curtain cord.

I go into the other room. He follows me with his "bang bangs" to the washing machine, where he puts up quite a racket, laughing all the time. He goes to his table, covered with animals. He grabs his stuffed elephant for a quick hug. He takes it to the front area where he has a couple of shelves of toys and starts to play in his car. He gets on, then off, opens up the seat and puts his elephant inside, puts a wooden toy inside.

After five minutes on and off, he gets off and picks out his elephant and wooden peg toy and brings them to show me, says "up," and climbs up to the couch where I am ... shows me peg, puts it in hole, has little spoon that he puts in hole, then offers food to his elephant, now he's pretending to eat with the little spoon. He's hugging his elephant, and alternately feeding himself and the elephant or putting the spoon in the holes. Looks up and yells, "Mommy!," then back to play ....

He's constantly moving ... Gets into position to imitate how I'm sitting ... then runs to his animals, then to his crayons. He loves to pick up lots of things and put them into boxes; now he's stuffing all the crayons into the crack in the sofa. This occupies him for 5-10 minutes, or so it seems—probably less. He wants his elephant and calls, "Mommy!," climbs back up to sit with me, rests a second, then down again ... He's getting tired. I get up to get him his bottle before his nap.

That was all 45 minutes or so. He really is an intent little person, can spend time by himself playing, putting one thing into another, very pleased at all his accomplishments. He likes an audience, that's for sure, when he's dancing or saying "bang bang" or laughing, but otherwise he plays with his toys and checks in every now and then.

I just reread that sequence and it makes me feel tired just to feel the constant motion. Yes, he'll rest for a long time in my arms before nap or sleeping, though he wants to be sung to. He'll say, "Mommy! La la la," meaning, "Sing to me." As long as he has his "teta" (bottle) and his "nyanya" (blanket), he'll lay still for awhile ....

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Attachment and exploration: The toddler's dilemma

by
Alicia F. Lieberman

This article is adapted from a book on the emotional life of the toddler, in preparation for The Free Press.

Being a toddler means being able to walk alone, moving back and forth between the world at large and the reassuring presence of the mother. Perhaps more dramatically than any other age, toddlerhood represents the tension between two ever present yet opposing human impulses: the exhilarating thrust of carefree, unrestricted, uninhibited exploration, where one can soar free without looking back at those who are left behind, and the longing to feel safe in the protective sphere of intimate relationships.

Toddlers feel this duality with unsurpassed passion, and their specific experiences have long-term implications. In many settings and under many different circumstances, toddlers—and their parents—need to negotiate a mutually satisfying balance between the safety of closeness and the excitement of exploration and discovery. In this sense, toddlerhood is an early laboratory for the challenges and dilemmas of adult life. Much of our individual style through life is determined by our unique way of expressing, balancing, and integrating these two impulses. Although we might experiment with different possibilities at different junctions in our lives, we tend to recreate again and again the unique balance between caution and daring, familiarity and adventure, intimacy and autonomy that in some intangible way feels most like "us."

Secure base behavior

Toddlerhood brings about a restructuring of the relationship between two basic motivational systems: the attachment system and the exploratory system. Because she can now move about independently, the toddler acquires a repertoire of behaviors, signalling the activation of each of these systems, that is different from the repertoire that was available to her as an infant (See Bowlby, J., 1973, 1982). The toddler's *attachment behaviors* of approaching, following, reaching for pick-up, hugging, cuddling, and clinging bring the child close to the parent. *Exploratory behaviors* take the child away from the parent, in order to walk, climb, run, jump, and inspect the world around.

As the child experiments with attachment and exploration, the parent, in turn, must become comfortable with two complementary sets of caregiving behaviors: *protective behaviors* that provide the toddler with nurturance and safety through proximity and closeness, and *letting go* behaviors that encourage the child to explore without fear. When things go well enough, the parent serves as a "secure base" (Ainsworth, M.D.S., Blehar, M.C., Waters, E. & Wall, S., 1978) from which the child sets forth to explore and to which he can trustingly return for solace, in case of internal stress or external danger, before moving off yet again.

The toddler's "secure base behavior"—his ability to use the parent as a haven of comfort and security—suggests the presence of an internal "monitoring system" that enables the child to assess environmental conditions and to signal when he is feeling safe and when he is experiencing worry, wariness or fear. Locomotion towards or away from the parent is an eloquent preverbal indicator of what the child is feeling. Seeking proximity and contact (attachment behavior) indicates that the child's understanding of the situation leads him to wish or need an increase in the feeling of security. Moving away behaviors suggest that the child feels safe enough and is looking for novelty rather than security.

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The ability to engage in secure base behavior makes the toddler an active partner in contributing to his own protection. For example, a naturalistic study conducted in London parks revealed that, with a few exceptions, toddlers seemed to determine their own boundaries and stayed within about 200 feet from their mothers, who remained seated on a bench or on the grass (Anderson, J.W., 1972). This perimeter happened to coincide with the mothers' own judgment of what constituted a safe distance. The mothers did not retrieve their children

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if they remained within this boundary, but did so if the toddlers strayed beyond it. However, nearly 70 percent of the children never went far enough to warrant retrieval.

Although they had the opportunity to wander off if they wished to, the toddlers managed their exploration in a way that kept them simultaneously free from

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In many settings and under many different circumstances, toddlers—and their parents—need to negotiate a mutually satisfying balance between the safety of closeness and the excitement of exploration and discovery. In this sense, toddlerhood is an early laboratory for the challenges and dilemmas of adult life.

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the mother's direct physical control and within a safe distance. The mother served as the organizing center for the child's activities, which included picking up objects from the ground to examine them, putting these objects in the mouth, holding on to structures offering support, and trying to shake or climb over obstacles. Interestingly, the children played in one place for long periods primarily when they were within three feet of their mothers; sorties farther afield were brief. In other words, the children felt most secure where it was actually safest, and they tended to spend more time there.

When playing away from the mother, the toddlers kept track of her whereabouts through quick visual tabs and periodic pointing to interesting sights. The mothers routinely ignored these behaviors, with one major exception: when a child pointed at a potential source of danger, such as a dog on the loose, the mother would call out to him to come closer, and get up to retrieve him if he did not comply. This suggests that pointing helps the child to learn what is safe and what is dangerous, through the mother's response.

In spite of their innate competence in seeking protection, children's safety depends largely on adults' more developed capacities. Biologically-based cues to danger (darkness, sudden loud noises, animals, being alone) do not serve to warn toddlers of the dangers of contemporary society—seemingly friendly strangers, dirty objects on the ground, passing cars, elevators. Accidents are the leading cause of death in early childhood, a chilling reminder of this fact.

Moreover, toddlers and caregivers may have sharply opposing views of what is safe.

- *Seth, 15 months, is mesmerized by the glowing embers in his family's fireplace. He lurches forward, and his mother barely manages to retrieve him in time. He screams: "Shiny! Shiny!"*

- *At 22 months, David refuses to hold his mother's hand while crossing the street. Cars and busy roads are a familiar feature of this urban child's life, and he sees adults using them with equanimity. He cannot understand that traffic poses a threat to his well-being. Why can't he cross the street on his own, like everybody else?*

- *Beth, 24 months, cannot fall asleep at night. "The monster will come in the dark," she says. Her parents know that monsters will not come in the dark, but they cannot persuade Beth of this fact. Leaving a night light on reassures her.*

- *Andy, 30 months old, cries every time he sees an African mask in his uncle's house. "Bad man," he says. Reassurances that the mask is not real are only marginally helpful in calming him down.*

Toddlers are always trying to make sense of what happens to them and around them, but the toddler and the adult do not see the world in the same way (see Fraiberg, 1959). As we try to understand attachment and exploration in toddlers, we must remember that these children reach their own idiosyncratic conclusions about cause and effect. They have definite ideas about the magnitude and limitations of their own and their parents' power; they develop unique theories about what is real and what is pretend, what is safe and what is scary, what is alive and what is inanimate.

These very particular notions gain momentum from the child's active imagination. Toddlers not only make correct as well as faulty inferences and generalizations about how the world works. They also fantasize about creatures and situations that in their minds are tangibly real. Just as children at this age believe in their own fantasies, they also grant concrete existence to the imaginary creations of adults, including drawings, masks, and television and movie characters. Understanding what is "real" and what is "pretend" is a slow and painstaking achievement that begins in toddlerhood but is not completed until much later (if at all).

This leads to many misunderstandings. Well-meaning adults, who would dash to rescue David from the consequences of his recklessness, might laugh at Andy's seemingly irrational terror. Yet the simplest way of relieving a toddler's fears is to take them seriously. Listening attentively, asking questions to clarify what the child believes, and offering a reassuring explanation as well as the promise of protection ("I won't let you get hurt!") are good ways of letting the toddler know that his perceptions are being respected and that the parent will make sure he is safe. Talking about "pretend" and "make believe" can also be greatly reassuring because these concepts help the child add an important new dimension to his understanding of physical and psychological reality.

Secure base as a metaphor

The above situations show that issues of security for the toddler are not raised by the experience of independent mobility alone. Every one of the child's encounters with her environment may engender a need for physical or emotional protection. Thus the concept of "secure base" as a balance between autonomy and protection is a useful metaphor for the toddler's encounters with many new dualities.

For human beings, attachment and exploration are ultimately in the service of developing a sense of oneself as a person who can, depending on the circumstances,

feel safe and protected, yet also outgoing, competent and independent. Depending on the subjective experience associated with each situation, coming close and moving away may variously represent:

- intimacy with others versus autonomy;
- social belonging versus individual fulfillment;
- being tied down versus soaring free;
- subservience and humiliation versus personal power;
- love versus hate and alienation.

The toddler experiences the whole range of these states because he is constantly facing circumstances that make him feel either powerful and strong or small and needy. For him, everything is possible until the world proves otherwise by crashing down around him, or making *him* come tumbling down. Depending on his inner state, the toddler is liable to dart off recklessly or to be clingy and want everything done for him. Experiencing fully each pole of these dualities without becoming fragmented is a life-long task. The initial momentum for this developmental process is acquired in the toddler years.

Parents—bewildered, exasperated, and exhausted though they may be by the toddler's lurching and reeling encounters with physical and emotional dualities—need to preserve enough inner balance to help their child through the experience of strong emotions, both negative and positive. In its broadest sense, a secure base represents the trust in oneself and others that comes from being allowed to explore safely, in the protective context of parental acceptance, not only the beckoning physical environment but also the wide range of feelings that emerge in the course of growing up.

Parents differ in their willingness and ability to allow themselves and their children to experience and express a variety of feelings. Toddlerhood puts even the most tolerant and resilient of parents to the test because of the rapid pace of emotional development. Willfulness, defiance, fits of rage, recklessness, sexual curiosity, coyness, possessiveness, disappointment, ecstatic pleasure, withdrawal—all these become components of the toddler's emotional repertoire. If adults went through a fraction of the quick alternation of moods and emotions so characteristic of toddlers, they would be in a permanent state of exhaustion.

Yet parents do experience these mood swings indirectly, through having to witness and modulate their children's experience. When the parents can manage to remain reliable enough ports of acceptance and reassurance, toddlers can learn to experience and explore a range of feelings, both pleasant and unpleasant, without fear of being emotionally abandoned or disowned. They can learn that their least palatable feelings are nevertheless acknowledged and accepted parts of themselves. These are the two basic components of an internalized secure base.

Developmental changes in secure base behavior

Toddlers' balance between attachment and exploratory behavior is never static: it fluctuates depending on many factors, including the specific situation, the parent's mood, and the child's mood. Sometimes the impulse to explore predominates for weeks at a time, only to be replaced by a period of clinginess so intense that the parents feel their child has seriously regressed. Other times the reverse is true. Periods of seeming dependence on the mother are superseded by a powerful thrust towards exploration, and the parents find themselves longing for a little more of the very dependence they had so recently worried about. In spite of these fluctuations, some broad developmental trends do emerge (Mahler, M.S., Pine, F., & Bergman, A., 1975), allowing us to describe the "junior toddler" and the "senior toddler."

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The junior toddler: Between about 12 and 18 months of age, toddlers are elated by their newly acquired ability to move around the world. Returns to the mother are often brief and may consist of no more than a touch. It is the forays into the world (which looks new and exciting from the upright position) that hold the greatest thrill. So absorbed can the toddler become in his new achievements that for awhile he may be quite oblivious to knocks and falls. The important thing is to keep on practicing locomotion, discovering, mastering.

Exhilaration is a key mood of this period. A favorite pastime is to run off again and again, only to squeal in delight on being pursued and scooped up by the mother. This game is of great symbolic importance for the junior toddler. It reassures him that mobility need

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not mean alienation or abandonment, and that the mother will not leave him to his own (fledgling) devices, but will *want* to retrieve him again and again. For a worn-out parent, this game may seem like an endless tease; for the toddler, it provides crucial reassurance that independence and togetherness can go hand in hand.

The best indicator of the toddler's wish and need to be retrieved is what happens when the parent does not do it: the toddler falls down or gets hurt, and the episode ends in tears instead of giggles. If the parent consistently dismisses the child's bids to be chased and safely retrieved, the implicit message may well be: "You are on your own, and going off in a giddy spree will get you in trouble." If this happens too often and the child learns that he has nobody to turn to when he goes off independently, the range of experience and feeling he learns to perceive as safe is prematurely narrowed down.

Locomotion puts the body at the center of the junior toddler's experience. Her legs can accomplish wonders: walk, climb, jump, run. The legs, in turn, are in the service of eager little hands: having climbed on the dresser, the toddler can reach that colorful porcelain doll that had always beckoned to her. Toddlers find new interest in their genitals, which they explore attentively and learn a name for. They experience an irresistible urge to bite as new baby teeth erupt in rapid succession. Many moments of intense absorption are spent poking at the belly button, fingering the genitals, looking in the mirror (where toddlers now recognize themselves), biting and chewing, examining toes.

Finding names for the important things of the world is as momentous an achievement as walking. There is a marvelous symmetry in the fact that the abilities to name and to walk occur at about the same time. The great myths of creation describe the world as coming into being through the Word. The human child, too, creates meaning through naming the world he is discovering. Some of the names coincide, exactly or approximately, with the labels adopted by the culture at large: "mamma," "daddy," "wow-wow" for dog, "ba-ba" (for bottle). Others are totally idiosyncratic, magically created by the child for her own personal use.

Language opens new vistas, just as walking does. The joy of creating meaning through words can be as exhilarating as the joy of creating new horizons through motion. And language, like locomotion, can be used to achieve security when necessary. Avi, 18 months, runs after a kitten and then realizes that he has ventured further from his mother than ever before. His face registers momentary shock and disbelief, but he quickly recovers and runs back to her, yelling: "Who coming to me? Who coming to me?" This is the call his mother uses (in the adult version) to entice him back when he strays too far, and he has now made it his own, to achieve security in a moment of need.

When parents or trusted caregivers are present, toddlers are free to feel elated with their new skills. In their absence, the child's mood becomes sober and low-keyed. Activity level slows down and interest in exploration diminishes. The toddler seems to turn inward, as if holding on to the reassuring memory of the absent parent or caregiver. The greeting welcoming the parent back conveys the relief that all is well again.

Some children may burst into tears on first seeing the parent, as a way of relieving pent-up tension. Others may "pick a fight" by becoming provocative or defiant. Ambivalence may be expressed by simultaneously clambering up on the parent and pushing away from her, or giving little kicks against her side. Sometimes the child's low-keyedness persists in the form of avoidance after the parent's return: looking away or even moving away from, rather than towards, the parent. Some toddlers continue to play as if nothing had happened, totally ignoring the parent's greeting. These various responses reflect the child's unique style of showing anger and distress about the parent's absence. The child may worry that the parent is not truly back and that she may leave soon again, either physically or emotionally. The child's ambivalent greeting is an effort to protect himself from yet another experience of disappointment through renewed separation.

When parents can manage to remain reliable enough ports of acceptance and reassurance, toddlers can learn to experience and explore a range of feelings, both pleasant and unpleasant, without fear of being emotionally abandoned or disowned.

Most frequently, however, toddlers greet their parents joyfully after a manageable separation. Here, too, the specific responses are quite varied and reflect the child's individual style. The toddler may smile or greet the parents from a distance, show them a toy, come close to them, insist on being picked up. All these are attachment-promoting rather than exploratory/distancing behaviors. These unambivalent responses indicate that the child, even during a temporary absence, trusts the parent's ongoing availability.

The senior toddler: By about 18 months, locomotion has been perfected and is no longer the driving obsession of the child's life. Instead of being a goal in itself, walking becomes the means to an end. The toddler's efforts shift from mastering locomotion per se to new goals that locomotion makes possible.

This evolution contains a psychological paradox. For many children, separation anxiety is at its highest at about 18 months. Longitudinal studies of children's responses to brief separations from the mother show that crying peaks at about this age and declines gradually thereafter. Similarly, Margaret Mahler and her colleagues (1975) describe the onset at this age of a behavior they call "shadowing," which refers to the child's incessant monitoring of the mother's every move.

Senior toddlers become more demanding of the mother's attention. Annie, at 22 months, began to yell: "Talk only with me" whenever her mother tried to maintain a conversation with others. Michael, aged 24 months, agreed to go on family outings only if his mother promised to sit next to him and speak to him alone during the car ride. The child wants to drink from the mother's glass and to eat from the mother's plate. He also offers the mother bits of his food and brings to her interesting objects, which he piles on her lap. A combination of escalating demands, screaming and tears often results when the wishes to have mommy all to oneself are not granted.

Being true to oneself is the most compelling motive of the healthy toddler. Every childrearing issue of this age can be understood at least partly in this light, including sleeping difficulties, toilet training, separation anxiety, the regulation of tantrums, and the transformation of physical aggression into the verbal articulation of anger.

Minor cuts and hurts may suddenly become quite distressing at this age, and objects that are broken or lost are the topic of questions and concern. These worries reflect the child's evolving sense that the body is not only a powerful vehicle for her will power but also a delicate instrument subject to hurt. The earlier omnipotence is now balanced by a sense of vulnerability, and the toddler will go back and forth between the two states before finding her own unique integration of daring and safety.

Why would the toddler become seemingly more needy just when he is more competent at being on his own? It makes sense to think that following a period of absorption in locomotion and exploration between 12 and 18 months, the toddler needs to rediscover the mother as the ongoing provider of protection and emotional support. Once he has mastered mobility, he also becomes more aware of the troubles it can bring. Perhaps precisely because he feels better able to stand on his own, the toddler can now indulge the wishes for protective closeness with mother that he ignored to a degree while he was learning to walk.

The metaphor of a secure base helps to explain this process. Just as moment to moment and day by day the child's needs fluctuate between exploration and attachment, so the growing child goes through extended periods in which either the wish to explore or the impulse to be close predominates. Much of toddlerhood can be understood in terms of the child's gradually coming to grips with these two motives, and integrating them into a unique individual style that becomes relatively stable through life.

While needier of the mother's attentiveness and emotional support than in earlier months, the senior toddler continues to make remarkable progress in cognitive and exploratory skills. The child's inner life becomes increasingly more accessible to the parent through language and symbolic play. He learns to label feelings as well as physical objects. Feelings that are not put in words can find expression in symbolic play or in reenactment.

Whereas the younger child worries primarily about the mother's *actual* whereabouts and is afraid of separation and loss, the senior toddler contends with a subtler but equally chilling fear: the mother's disapproval. This he equates (quite understandably) with losing her love. Some of the most meaningful dialogues of this age unfold around the mother's message that "even when I am angry at you, I still love you." This unbelievably good news is assimilated only gradually by the toddler, who needs to perform an impressive cognitive feat to understand it. He has to balance the immediate and powerfully concrete experiences of the mother's angry face and booming

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voice (or, in the case of more controlled types, her uncharacteristically cold demeanor) with the accumulated memory of past loving exchanges that, at the moment, may seem too distant to be relied upon. Holding on to a reassuring past in the face of a threatening present is hard to do. Even some adults have been known to lose faith when faced with such an ordeal. In all truth, parents often have to remind themselves that they *can* love and be angry at the same time, and are relieved to learn this once again in the very process of reassuring their child.

The fear of losing the parent's love looms large for the senior toddler, since the period between 24 and 36 months is when children in our culture typically confront the demands of civilization—refraining from hitting and biting, sharing toys with a peer, becoming toilet trained. The wish for approval is the parent's most reliable ally in the process of helping the child form a conscience. Yet the toddler must risk the loss of the

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parent's love again and again, for the child's most important task once more involves a balance: becoming an acceptable social creature without giving up her innermost wishes and longings.

Being true to oneself is the most compelling motive of the healthy toddler. Every childrearing issue of this age can be understood at least partly in this light, including sleeping difficulties, toilet training, separation anxiety, the regulation of tantrums, and the transformation of physical aggression into the verbal articulation of anger. The cycle of parent/child disagreement-resolution-reconciliation, occurring with greater or lesser intensity throughout the day, is a cornerstone of the toddler's psychological growth. It allows him to know that he is not a clone of the parent but has an autonomous will, that disagreements with loved ones are inevitable, and that anger can be experienced and survived.

A child who is growing well seeks approval but is not obsessed by it, can tolerate reasonable amounts of frustration, and can go back and forth flexibly between asserting his will and complying with the will of others. A child who is having difficulty can be excessively worried about losing love, and hence too passively compliant. Alternatively, a toddler may become overly invested in defiance as the only way he knows of pursuing his personal agenda in the face of parental opposition. Either reaction signals a restriction in the range of affect and possibility available to the child. The healthy child feels comfortable with a full range of his emotions and will refuse to be seduced into acknowledging only his cheerful or compliant side. Michael, 36 months, was laughing joyfully, and his mother asked him in a transport of delight: "Are you a happy boy?" His instant answer: "I am happy and sad and angry and bitey and clingy."

Michael was asserting something his mother had temporarily lost sight of: his integrity as a fully sentient human being with a rich diversity of emotional experience. He was saying that all his feelings were part of him, good and bad, pleasurable and distressing. He felt safe in his completeness, the most reliable indication that he had internalized a secure emotional base.

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State Regulations Concerning Toddlers in Child Care

by

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National Center for Clinical Infant Programs

Toddlers—children from 12 to 36 months of age—need frequent and sensitive interactions with trusted adults as they move out to explore their physical and social world. They also need space to move and test their developing physical skills. When toddlers are in a child care setting where too many children are crowded together in one group or when too few adults are available to give each child individual attention, neither of these needs can be met. Not surprisingly, the two variables that have long been recognized as important indicators of child care quality are group size and child-staff ratio (Phillips, 1987; Roupp, Travers, Glantz & Coelen, 1979; Whitebook, Howes & Phillips, 1990). The National Academy of Early Childhood Programs adopted standards that reflect what child development specialists believe are acceptable relationships between group size and child-staff ratio in child care centers (Bredekamp, 1984). (Table 1)

Table 1: National Academy of Early Childhood Programs Accreditation Criteria for Child:Staff Ratios Within Group Sizes

	Group Size				
Child Age	*6*	*8*	*10*	*12*	*14*
6-12 months	3:1	4:1			
12-24	3:1	4:1	5:1	6:1	
24-36		4:1	5:1	6:1	
2/3 yr mixed group			5:1	6:1	7:1

Responsibility for regulating and monitoring the quality of child care rests with state and, in some cases, municipal government. Regulations provide a floor of quality below which no licensed or registered program should fall. Unfortunately, most state regulations governing child care for toddlers are far less stringent than the National Academy standards. Moreover, while regulations on group care for infants (children under 12 months of age) have received increasing attention by researchers and policy makers (Zigler & Frank, 1988) and in some cases have been strengthened in recent years, those concerning toddler care have received less consideration.

State regulations cover two forms of child care—child care centers and family day care homes. Regulations vary considerably in their basic definitions (e.g., what age range constitutes "toddlerhood?" or who can be counted as a caregiver for a group of toddlers?) as well as in their specific requirements (e.g., whether child-staff ratios must be consistent throughout centers' hours of operation). In order to reduce some of the problems of comparability across states, Morgan (in

press), provides a "snapshot" of regulations affecting toddlers in center-based care. Tables 2 and 3 are adapted from her data.

Table 2: Group Size for Toddlers in Child Care Centers—State Regulations Compared at Two Child Ages (adapted from Morgan, in press)

	Group Size									
Child Age	*4*	*6*	*8*	*10*	*12*	*14*	*16*	*18*	*≥20*	*N.R.**
6 months	1**	2	14	4	4	1			3	23
18 months		2	8	6	2	5	2	1	3	23
24 months			5	4	4	6	6		6	23

Child age: Morgan provides comparisons using a specific age to reduce problems of variability between states
*N.R. means not regulated
**Number of states or jurisdictions requiring this group size

Table 3: Child:Staff Ratio for Toddlers in Child Care Centers—State Regulations Compared at Two Child Ages (adapted from Morgan, in press)

	*Child:Staff Ratio**										
Child Age	*3:1*	*4:1*	*5:1*	*6:1*	*7:1*	*8:1*	*9:1*	*10:1*	*11:1*	*12:1*	*≥13:1*
6 months	3**	28	9	7	2	1				1	
18 months		1	15	11	7	7	5	3	2		1
24 months			7	8	6	8	12	1	5	1	6

Child age: Morgan provides comparisons using a specific age to reduce problems of variability between states
*Child staff ratio is the number of children permitted per caregiver within a group
**Number of states or jurisdictions requiring this group size

Morgan (in press) reports that nearly half of the states (23) have no group size requirements for toddlers in child care centers. Of the remainder, eleven exceed the National Academy's standards on group size for children between 12 and 24 months. Three states permit group sizes larger than twenty (24 in North Carolina, 25 in Utah, and 35 in Texas). Eighteen exceed the standards for two-year-olds. (Table 2)

Most states do regulate child-staff ratios; however, only sixteen meet National Academy standards for toddlers under two years of age and only seven states meet the standards for two-year-olds. Ten states allow one caregiver to care for 8 or more toddlers 18 months of age, while thirteen permit one caregiver to care for 10 or more two-year-olds. (Table 3)

Comparisons among states are more difficult when other forms of child care are considered. Family day care, for example, is licensed or registered in all but two states (Louisiana and Mississippi), but the majority of programs remain unregulated. States differ widely on how family day care is defined (e.g., number of children under age two permitted in care, whether the provider's own children must be counted, and whether school age children are allowed on a part-time basis). The Children's Defense Fund (1990) estimates that two-thirds of all states do not meet the National Academy standards for group size in their family day care homes. Since the majority of family day care homes involve only one caregiver, group size and the ages of the children in care are critical factors.

The disparity between standards set by child development experts and the realities of regulated care is disturbing. There are too many examples of large numbers of toddlers in groups with one caregiver and too many states that do not even regulate group size. The lack of data on both regulated or registered and nonregulated family day care contributes to the belief that many toddlers are in less than optimal caregiving settings.

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Mainstreamed, Mixed-age Groups of Infants and Toddlers at the Bank Street Family Center

by
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The setting is the Bank Street Family Center in New York City. Three children are seated at a small table, each with a dish of paint, paper, and brush. Charlie, aged 2.11, carefully paints his left hand, one finger at a time. He presses the now red hand firmly onto the paper. "Look!" he exclaims to the caregiver, eyeing the hand print, "I did it!" Gabe, 2.3, makes sweeping strokes of red on his paper, then swirls the wooden handle tip through the painted marks. "You used both ends of the brush on your paper," the caregiver comments. Melanie, 11 months, dips her brush in the paint and examines the trail it leaves on her paper. She feels the paint with her hand, puts the brush into her mouth, then makes more marks on the paper. The three children are absorbed in painting for nearly 20 minutes.

Mixed-age groups of children six months to three years old interact with one another in many different ways every day in the Bank Street Family Center, a full-day, mainstreamed child care facility at Bank Street College of Education. The Center's intent is to replicate the natural age span that occurs among children in family groups. Each of the Center's two infant/toddler groups consists of at most 10 children, two of whom are under a year old, and one or two of whom have a specific disability. The limit of two babies younger than one year per group reflects the great amount of attention young babies need. There are three caregivers in each group at all times. Families can choose to enroll their children for time slots ranging from three half-days to five full days per week. It is possible for a child and family to continue with the same caregiver for two years and to remain in the Family Center itself for three years.

Although very little has been written about mixed-age grouping of young children, particularly infants and toddlers, anthropologist Melvin Konner reminds us that grouping children in same-age groups is a fairly recent phenomenon, designed by adults rather than chosen by children. He notes that

> (in) human hunter-gatherers, in all apes, in almost all monkeys that have been studied, the nearly ubiquitous play group is a nonpeer, multiage group of juveniles. The advantages of the multiage composition of play groups for transmitting nongenetic aspects of behavior in higher animals, for protecting younger children, and for facilitating smooth integration of infants into a wider social world, are clear. (1975, p. 122)

When children form groups spontaneously, they are not rigid about the age of their playmates. Ellis, Rogoff and Cromer (cited in Katz, 1990) observed that children in spontaneous groups chose to play with same-age peers six percent of the time, but chose playmates who differed by at least a year in age from themselves 55 percent of the time.

Konner sees the relations of children of different ages as constituting a distinct "affectional system" (p. 123). Such a system can be readily observed in the Family Center: children bring toys or bottles to another, embrace another, play alongside or with another, grab playthings, push or hit another, or take another's food. Many of the children's feelings and experiences with each other in the center mirror those that exist between siblings or among children's friends in the wider community. Indeed one of the advantages of a mixed-age child care setting is the opportunity it affords children who have older or younger siblings to express some of their rivalrous feelings in a non-judgmental environment. In addition, the mixed-age setting gives single children the experience of a child-populated milieu.

In the following anecdote, a toddler expresses her feelings about a sibling figure within the benign setting of the Family Center.

Sam, 8 months, is on Joyce's lap, engaged in a "drop the clothespin into the can" game. When Joyce drops the clothespins, Sam retrieves, then chews on them. Twenty-three-month-old Zoe watches from across the room. Suddenly, Zoe swoops in close to Sam, hugs him roughly around the neck, grabs the clothespin from his mouth, and runs off into the other room. Sam screams. Joyce comforts him. In a few minutes, Zoe returns. She hands the clothespin to Sam. "First you took it away, and now you're giving it back," Joyce observes to Zoe.

Sam was startled, but not hurt. He learned that although an older child can be a threat, he can count on the adult to protect him. And Zoe, who responded to an impulse, had time to feel some twinge of guilt as she raced around, clutching Sam's clothespin. On returning the object, Zoe learned that a prosocial act is worthwhile—it has its own rewards.

Opportunities for social development among children

The mixed-age group provides many opportunities for children to develop social, caring and nurturing capacities. Particularly before they begin to talk fluently, toddlers learn a great deal by imitating the behavior of children who are both older and younger than themselves. During the 16 to 32 month period, imitation can be seen as a "developmentally mature act" (Eckerman, Davis & Didow, 1989, p. 450) that will help toddlers become full partners in play with other children.

However, toddler interactions in the mixed-age group are not limited to imitation. A recent study of children 18 months and 24 months (Brownell, 1990) found that pairing a younger and an older child led to more interaction and more turn taking than occurred with pairs of children the same age. One- and two-year-olds were seen actively *adjusting* their behavior to others, not merely imitating. The older children in the mixed

dyads made more complex and frequent social overtures to their younger partners than to their same-age peers. The 18-month-olds were more interactive with two-year-olds than with their exact contemporaries. In a study of larger groups of children, Goldman (1981) found that a mix of ages facilitated the social participation of both older and younger preschool children.

We might speculate that children in a mixed-age setting begin to learn what to expect from older and younger playmates and how to behave toward them. Children in primary school mixed-age classes look to older children in the group for leadership and help, and are drawn to give "sympathy" to younger children (French, 1984). In the Family Center, we see three-year-olds organizing the play in which two-year-olds take part. We see two-year-olds often comforting and gently patting one-year-olds and infants. Perhaps these behaviors are the precursors of altruism.

Relationships in the mixed-age group may also represent the beginnings of true friendship (Hartup, 1975). We frequently see infants as young as seven or eight months expressing preferences among children in the group. They become excited when a special friend arrives for the day, may offer a tangible "gift" to another child, or become agitated when a less favorite child makes an overture.

Opportunities for social development through continuity of care

A child enrolled in a mixed-age group at the Family Center is virtually assured of remaining with the same caregivers and some of the same children for at least two years. Because stability of caregivers and of the child care setting are associated with the development of social competence (Howes & Stewart, 1987), this arrangement offers a distinct advantage to children and families.

Howes (1988) found that toddlers who spent a year or more together in a group were more socially competent and had less difficulty with each other than children who had been in the group less than a year. Further, children who moved with their friends to a new group had less difficulty adjusting to the new group than children who moved without friends.

Based on these empirical findings as well as our conceptual understanding of the importance of early relationships, the Family Center makes every attempt to provide continuity of care. Sam, who entered as a six-month-old, will be cared for by the same person next fall when he is 18 months old. It is even possible that he will be with the same caregiver the following year, when he is 30 months old. Changes occur in the child membership of the group only when the older children go to the preschool group and younger children enter. Children are *not* moved when they reach a certain age or attain a specific skill, like walking.

Opportunities for learning skills

In the family, children who are six months to three years old reach, mouth, grasp, babble, feed themselves, crawl, walk, talk, and make-believe. In the Family Center, children learn many different skills from one another. In the following anecdote, children learn how to enjoy singing together and observe the skill involved in playing a musical "instrument."

Nine children, aged 18 to 38 months, are sitting comfortably in a circle with three caregivers. Bess, the caregiver, has given each child a pair of percussion sticks and starts to sing a familiar song while tapping her sticks together. All the children are very absorbed in the songs, even though only the older ones sing and play consistently. The three-year-olds "play" their sticks and sing most of the words. Twenty-three-month-old Helen sits, watching the three-year-olds; after the third song, she begins to tap her sticks together once or twice. As the singing ends, Rosie, 20 months, sings "Ba, ba, ba!," strikes her sticks, and smiles broadly.

The mixed-age group fosters skill in pretend play. While Piaget postulated that children begin "role enactment" at age three, Dunn and Dale (1984) found that two-year-olds who play with mother and older siblings begin "to understand, cooperate in, and contribute to joint pretend play considerably earlier than supposed" (p. 134). While not yet able to "plan" the play, two-year-olds can perform the roles assigned them.

Indeed, Vygotsky's concept of the "zone of proximal development" (1978) may provide a more relevant model for understanding mixed-age groups than Piaget's observations. Vygotsky defines the zone of proximal development as

> the distance between the *actual* developmental level, as determined by independent problem solving, and the level of *potential* development, as determined through problem solving under adult guidance or *in collaboration with more capable peers* .... what is in the zone of proximal development today will be the actual developmental level tomorrow—that is, what a child can do with assistance today she will be able to do by herself tomorrow. (pp. 86-87, emphasis added)

Playing with both older and younger children provides intellectual and social challenges that guide the less mature, younger child to internalize new understandings and skills. Seasoned child care providers (Hignett and Rossiter, n.d.) know the value of two-year-olds watching three- and four-year-olds using the toilet. The father of a 10-month-old, watching his baby interact with older children in the Family Center, exclaims, "He's so sophisticated!" It is important to remember, of course, that just as in a real family, children in a mixed-age child care group need individualized attention. In order to meet the needs of the wide age range in Family Center groups and to minimize the press of the group during the long day, the caregivers frequently divide the children into smaller groups. In the morning, for example, two children and a caregiver may go out to buy fruit for snack at the local market; three others may take a walk around the building; and the remaining four or five may stay in the room to paint, play with water, sand or dough,

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or read stories. The infants, meanwhile, may be sleeping in the nap room.

Mainstreaming at the Family Center

Within its mixed-age setting, the Family Center is committed to providing a mainstreamed environment for differently abled very young children. Twenty percent of the children in the Center have cerebral palsy, spina bifida, down syndrome, or developmental delays due to premature birth. A special educator coordinates special services, engages in the classroom with each child and teacher, and works closely with their families. She coordinates the Individualized Family Service Plan (IFSP) and the Individualized Educational Plan (IEP) for preschool children. An occupational therapist, physical therapist, and speech therapists provide services on site, most frequently in the child's classroom, so that the child's schedule is not disrupted by being removed from the group. By watching therapists in the classroom, caregivers learn new ways of participating in the child's development.

There is nothing mysterious or hidden about any child's disability. Children's questions are answered clearly and directly. "Nat wears braces to help strengthen his legs. He's not able to walk on his legs." Other children are often included in the work of the therapist and child with a disability, as the following anecdote shows.

The OT is seated on the floor. Nat, aged 3.3, is in front of her, facing out. As she works on positioning his legs, she plays a make-believe game with him that involves a group of animal figures. In the game, the pig is hungry. Nat says he can have spaghetti and meatballs. A child sitting nearby joins the game. She and Nat decide to have a meatball party and invite the bear. Tom, 2.6, and Rosie, 20 months, are absorbed in watching. As the play develops, the OT continues to position Nat's legs.

The children who are mainstreamed engage in all the activities offered at the Family Center. Wearing his leg braces, Nat crawls to the activities he chooses and plays freely with other children. Totally integrated into the group, he is a verbal, delightful three-year-old and a devoted block builder.

Family Center staff have had to learn to empathize with differently abled children without feeling sorry for them. This process has involved a growing awareness that caregivers cannot permit the children with disabilities to insist that other children conform to their limitations. For example, although some children enjoy crawling along with Nat, at some point their game will come to an end. The others will run off or climb up to the loft. The child with cerebral palsy is left behind, unable to participate. The staff must be supportive and straightforward in helping him come to terms with his situation.

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This is a challenge for the staff. "We give Nat options," explains Karen Chaglasian, the special educator. "If he agreed, we would pick him up and run with him, holding him down at the level of the other children. Or we might ask if he wants to ride a scooter to go fast with the others. We don't point out what he can't do—he already knows that."

"All the children have options," Chaglasian continues. She describes an instance in which a group of children including Gayle, who was in a wheelchair, were painting each other's legs with water. The children were unable to reach Gayle's legs, so they painted the wheels. "All the children had a choice of how to adapt and continue the play."

The caregiver's experience in a mixed-age setting: Staff reflections

Family Center staff enjoy the challenge of planning materials and activities that are appropriate for the wide age span in their groups. They rely on open-ended materials with a wide appeal. Amy Flynn, a head teacher, believes that using water, paint, sand and dough "helps you understand the many ways a material can be used, above and beyond your own adult conception."

Staff must be able to shift focus. They must consider the approach to use when the whole mixed-age group is together. They must be able to work in small groups, sometimes with children the same age and sometimes with mixed ages. Above all, they are challenged to think about individual children—apart from the group and developmental issues. Consistent and well-conceived staff development is important to help caregivers take advantage of the setting's great potential for learning. Laura Guarino, the Family Center's director, notes the need for constant communication, throughout the day, between herself and staff members.

"I would never go back to caring for just babies, as I did in my former job," says Barbara Abel, a head teacher at the Family Center. "You can't give the individual attention to three or four babies that you can to two babies." Still, the need to assure babies' safety is a real challenge. Infants must be protected from all sorts of physical danger (including the temptation to taste crayons, paint and glue) as well as jealous or curious toddlers.

Abel enjoys the wide age range at the Family Center. She loves to see the two's beginning to emulate the three's. Even a range of three months to 15-18 months seems too narrow to Abel

> because the developmental issues around autonomy are so pressing for all of them—there are no older children in the group with some developed controls to provide a balance. You're dealing with all the same developmental issues at once, and because the young toddler's conflict is between being a baby and being big, the babies often become their targets.

She finds little biting and hitting in the mixed-age group. When older children help the younger ones, they are doing what was done to them. The caregiver provides a consistent example, since she is with the children over a long period of time. She has seen them go through varying developmental phases and knows them very well.

Parent reflections

When prospective parents visit the Family Center, Laura Guarino describes the commitment to mainstreaming and mixed-age groups. Before parents see the classrooms, she prepares them and guides their observations toward the children's interactions.

Occasionally, a parent of a two-and-a-half- or three-year-old child in the mixed group will ask if the child is bored. Observing the child in action and talking with the teacher usually allays the parent's fears. Sometimes a parent will worry that the two-year-old who was just weaned will "fall apart" seeing one-year-olds with their bottles. Ms. Guarino reminds the parent that "development isn't linear. If children backtrack a little, they'll still move forward." Parents who do choose the Family Center are enthusiastically supportive of the program. They especially like the chance to build a continuing relationship with the same teachers over two years.

In sum . . . . .

The mixed-age, mainstreamed Family Center is a place where children, staff and parents grow and learn together. It is a setting that respects and embraces individual differences as the zest of life.

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The Transition Process for Toddlers with Special Needs and Their Families

by
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Transitions can be stressful for children, parents and the professionals who work with them. Toddlerhood is a period of development full of transitions, as the child's emerging capacities evoke new responses and expectations from parents, caregivers and community institutions. For children with special needs, their parents, and the service system, the transitions that accompany toddlerhood can be particularly complex. Yet transition is a fact of life for such families, who may experience transitions from neonatal intensive care unit to home, from home-based early intervention to a center-based program, or from self-contained to integrated setting, all within the child's first three years.

Ideally such transitions reflect responses to the child's changing developmental needs. However, transitions may also be occasioned by parents' need to work outside the home or by the structure of early intervention services available in the community. When a transition is imminent, some families will be able to choose from a range of acceptable options; others may feel caught in a "take it or leave it" situation.

Early intervention professionals are becoming ever more sensitive to the importance of working in partnership with parents to identify needs and concerns related to transitions and to plan specific steps to meet these needs. (The Education of the Handicapped Act Amendments of 1986 [P.L. 99-457] requires attention to transition issues.) This article describes the phases and tasks of a well-planned transition process, one that is likely to help a time of change become a time of growth, for both the parent(s) and the child with special needs.

In our work at the Family, Infant and Preschool Program, we have been looking at a variety of transition situations (Bennett, T., Nelson, D.E. and Lingerfelt, B.V., in press). In this article, however, we will focus specifically on the process of transition to out-of-home care for toddlers (children aged 12 to 36 months) with special needs and their families.

Developmental tasks of the toddler with special needs

As many observers have noted (see Murphy, this issue and Lieberman, this issue), toddlerhood is a time of enormous change and challenge for any child. The toddler's changing world includes the emergence of a sense of self and autonomy, self-control, separation and individualization, as well as the emergence of some of the strongest emotions human beings experience. Learning to walk independently and to speak offer the typically developing toddler growing control over the physical environment and people in it. The child with special health or developmental needs may require assistance in finding other satisfying ways to explore and communicate.

Every toddler is unique in his or her biological endowment, pattern and pace of maturation, and temperament. Indeed, the variations among "normally" developing toddlers of the same age may often be as great as the differences between these children and many toddlers with special needs. This does not, however, justify making a placement for a toddler with special needs in a setting such as an integrated infant/toddler center solely on the basis of his or her chronological age. It is critical to consider the developmental needs and tasks confronting the individual child, as well as the child's temperament, level of emotional development, and style of coping with change.

Entry into out-of-home care, with new peers, new caregivers, and a new physical environment, represents a major adjustment for any young child. The "social emotions" of empathy, altruism, guilt and contempt (Izard and Dougherty, 1980) that emerge in toddlerhood help the child adjust to the social demands of the world, new people, and new situations.

Parents' concerns about out-of-home group care of toddlers with special needs

Ironically, the very strengths of a good home-based early intervention program may make parents apprehensive about the transition to center-based care for their toddler. In a home-based program, logistics may be easier for the family. When the home visitor has been the same over time, a relationship of mutual respect, trust and loyalty between the parents and the professional is likely to develop. Parents are strengthened in their role as primary caregivers for their child and are likely, as well, to feel successful as teachers of their children, taking pride in their accomplishments.

Whenever parents prepare for the first time to leave their child with unfamiliar people on a daily basis, they may feel anxious about the separation as representing a loss of control over their child's well-being and development (Hanline & Knowlton, 1988). Parents of children with special health care and developmental needs may have particular concerns about a group setting. Some toddlers may require special physical care that is not a routine part of the caregiving repertoire in the group setting. The possible ill effects of the group care setting on the child's health may be of concern. Parents may wonder whether caregivers will understand their child's strengths and the unique ways in which their child is developing. In sum, will the early intervention experiences offered in the group setting *truly* enhance the toddler's development?

Some of the material in this article is adapted from a training module on facilitating transitions, to be published by Communication Skill Builders, Tucson, Arizona, in 1992.

Addressing these concerns calls for strong working relationships among parents, the "sending" professional (the home-based early intervention specialist), and the "receiving" professionals (the center-based staff). A carefully planned transition process can confirm parents as decision-makers for their child; recognize the home-based early interventionist's attachment to the child and family, and pride in their accomplishments; and prepare center staff to integrate the child in their setting.

The transition process

We have identified six phases in an ideal transition process (Bennett, Nelson, & Lingerfelt, in press). Such a process plans transitions to meet the developmental needs of toddlers and to address the concerns of their parents. The series of steps is designed to assure a smooth transition, with appropriate, comfortable roles for the parents and professionals involved in the partnership.

Phase 1: Discussing objectives, roles, and responsibilities regarding the transition

Most experts recommend starting discussion about an upcoming transition as soon as possible. Certainly parents whose child will be "aging out" of an early intervention program need to be aware at least a year beforehand that a transition will occur. Clarifying objectives and discussing roles and responsibilities help the family to organize the transition process. Parents and professionals each need to be aware of how they view their own and each other's role.

Phase 2: Developing a timeline for a smooth, sequential transition

A transition timeline allows families and professionals to understand and prepare for specific events in the transition process. Everyone involved should take part in listing what needs to be done and when it needs to be accomplished. The sample timeline in Figure 1, developed primarily for families going from home-based to center-based programs, facilitates assignment of responsibility for specific tasks and recording of projected and actual dates of completion.

Phase 3: Visiting and evaluating program options

Actually observing the programs that may be their toddler's next environment is one of the most important steps for parents in the transition process. The list for parents in Figure 2 guides parents' observations of the classroom environment, physical facilities, daily routines, and teacher/child interactions. The list also suggests areas of program policy and practice, not necessarily observable in a classroom visit, that parents will want to know about. These include transportation services, medical and developmental services, parent involvement, and the capacity of the program to meet the unique needs of the child.

The list of questions is designed to help families become familiar with their child's next environment and to help both parents and receiving professionals create the best possible environment for the child. The observation guide is *not* a tool to evaluate teachers or their classroom. There are no absolute right or wrong answers to the questions, although obviously some environments will be more suitable than others for a particular child.

Phase 4: Making the final choice of program

Parents can use the observation lists in discussions with early intervention professionals to compare and contrast the program options available to their toddlers. The lists can be useful guides in discussing what might be done to prepare the child, staff and environment for a successful transition to a particular program. It must be recognized that some families have few or no appropriate program options. These discussions should also be seen as opportunities for parents and professionals to raise concerns about the overall transition process.

Ultimately, the family makes the choice.

Phase 5: Exchanging information

Once the family has chosen a center-based program for their toddler with special needs, parents, child, and program staff should learn as much as possible about each other before the transition takes place. Much more than a transfer of records is involved. It is wise to remember that transition is an important time not only for the child and the family, but also for the "sending" and "receiving" professionals. The exchange of information during transition can help build positive relationships if participants accept specific responsibilities.

The home-based "sending" professional should:

- obtain parents' permission to send the child's records to the new program and discuss them with the "receiving" center-based teacher;
- arrange to meet with the "receiving" teacher and the parents to discuss the child's record (and remember that it's *their* meeting);
- encourage the parent(s) and child to visit the new program on a regular, frequent basis before transition, particularly during free play time; and
- ensure follow-up once the child is attending the center regularly.

The center-based "receiving" professional should:

- review the child's records, noting questions and/or the need for additional information;
- arrange to meet with the parents and other professionals involved with the child; request additional information as needed;
- invite the parents, child, and sending professional to visit the center (inviting the parents, in addition, to drop in at any time for informal visits);
- make a home visit to the family;
- explain the center program fully to parents, including daily and vacation hours of operation, daily routines, etc.

continued after insert

Transition Timeline

Transitioning Child _____

DOB _____

Parent/Legal Guardian _____

Transition Date _____

Preparations	Projected Date(s)	Responsible Person	Date of Completion
1. Discussion of the transition process begins with the family.			
2. A timeline of events is developed.			
3. Family visits and evaluates program options and discusses with case coordinator their insights.			
4. Family decides on a final program choice.			
5. Family visits classroom program.			
6. Classroom staff visit the family.			
7. Program staff have meetings to discuss the family's concerns.			
8. Family prepares child at home for the transition.			
9. Programs exchange records and files.			
10. Actual transition event occurs.			
11. IFSP goals are developed.			
12. Program staff involved in follow-up.			

Adapted from: Bennett, T.C., Nelson, D.E. & Lingerfelt, B.V. (in press). *Facilitating transitions to other settings.* Tucson, AZ: Communication Skill Builders.

Parents should:

- discuss the program they have chosen for their toddler with both the sending and receiving professionals;
- visit the new program, themselves and with their child, participating in free play;
- list questions and concerns raised by program visits and discuss these with sending and receiving professionals;
- invite the receiving teacher to visit the child and family in the home;
- express their goals for the child to the receiving teacher;
- participate in the development of the new Individualized Family Service Plan.

Phase 6: The actual transition

A toddler's full-time attendance at a center-based program should ideally be preceded by a period of frequent, regular visiting. Once actual enrollment occurs, the child may, as appropriate, be encouraged to attend the program for short periods of time, gradually working up to full-time attendance. If the toddler will be attending without the parent, as in a child care setting, a gradual separation process should be planned that is comfortable for child, parent and teaching staff.

Phase 7: Initiating and carrying out follow-up

Follow-up by the sending agency is one of the most important aspects of the transition process. Follow-up provides support and reinforcement to the family, as well as offering an opportunity to raise concerns. Parents, sending professionals, and receiving professionals should all feel free to call one another to talk or ask questions.

Kate and her family in transition

The experience of Sarah, Tom and their 12-month-old daughter Kate illustrates the phases of transition from home-based early intervention to an integrated child care setting.

Kate has many medical complications as a result of her birth at 28 weeks gestation. When Kate was sent home on an apnea monitor after 12 weeks in the Neonatal Intensive Care Unit, her parents were concerned about how she would fare in a child care setting when Sarah returned to work during Kate's second year of life. Would the classroom staff be able to give her the kind of attention she needed? Would Kate be safe in a group of freely mobile children? Would she be left out of activities because she couldn't follow the other children? How would Kate respond when Sarah left her?

Sarah and Tom shared these concerns with the home visitor who had seen Kate during her first year. Together they worked out a plan for exploring early

Parent Checklist for Observing Infant/Toddler/Preschool Classrooms

I. Context

- How many children are in the classroom?
- What is the (developmental) age range?
- How many teachers, teacher's aides and volunteers will be present in the classroom?
- How many children with special needs are there in the classroom?
- If the classroom is a self-contained special education classroom, will your child have opportunities to spend time with children from other classrooms?

II. Arrangement of the environment

- Are the toys and activities of interest to the children?
- Are there enough toys?
- Are areas for different activities clearly defined by low barriers, rugs or other outlines?
- Can the teacher see all of the children?
- Are there areas for loud and quiet activities?
- Is the environment safe? Are electrical outlets covered? Are cleaning supplies stored out of reach?
- Is there clear access to tables and pathways for a child with special needs, and room for travel chairs, corner chairs, and other equipment?
- Are materials at the child's eye level?
- Is the playground area appropriate for your child? Does the playground have suitable adaptive equipment?

III. Program activities

- Are activities carefully chosen to reflect and promote the child's ability to behave appropriately in real life situations?
- Do the children seem involved in activities?
- Do the children have to wait at any time during the day?
- Are activities too simple or too difficult?
- Can children move in and out of activities, following their interest?

IV. Daily routines

- Do the bathroom facilities and diapering/toileting routines meet your child's specific needs? If not, what suggestions do you have?
- Examine the lunch facilities, utensils and routines. Determine modifications that can be made to meet your child's needs.
- Will transportation be provided for your child? What special assistance may be required?
- How will special services (physical therapy, occupational therapy, etc.) be incorporated into your child's program? Can support services be integrated into the classroom routine?
- Will classroom staff need to give medication to your child routinely or carry out other procedures, such as tube feeding?

V. Staff interaction with children

- Do teachers respond to the children's lead rather than imposing their own definition of what the children should be doing?
- How do teachers acknowledge children's accomplishments?
- How do teachers help children when they are disruptive?
- How much individual attention does each child receive?

VI. Staff interaction with parents

- Are parents free to visit the program at any time?
- How is information shared formally—for example, through notes, a newsletter, scheduled phone calls and conferences?
- Do teachers seem to chat with parents at drop-off at pick-up time? Return phone calls from parents? Comment positively about children and families? Ask about home routines and the child's interests?
- Does the program encourage active parent involvement?
- How open is the staff to parent suggestions and requests?

intervention programs and other child care options, preparing for a fall entrance, when Kate would be 15 months old.

Sarah and the home visitor agreed that they would find out more about a classroom program with hours that met the needs of working families. Sarah looked over the observation checklist to mark questions pertinent to Kate's situation. When the home visitor contacted the classroom teacher, the teacher offered to accompany the home visitor to talk with Sarah, Tom and Kate. During this visit, the teacher was able to answer many of Sarah's questions and to make an appointment for both parents and the home visitor to visit the center together.

Sarah and Tom toured the entire center and observed the classroom that Kate might attend particularly carefully. The teacher describe the daily schedule and activities and was able to answer Sarah's questions about including Kate in all activities. Seeing the classroom that Kate might enter and the children who would be her playmates, and discussing their questions with the teacher and the home visitor, made Sarah and Tom more comfortable. When Sarah and Kate visited the program the following week, Sarah was able to see how Kate could "survive" in a group of children. Staff were able to ask Sarah many questions about Kate.

Although Sarah felt very positive about the classroom program, she, Tom, and the home visitor investigated other options before making a final decision. When the parents did decide that the center-based classroom was the program they wanted for Kate, they began quickly to prepare for the fall.

Sarah contacted Debbie, the classroom teacher, and made an appointment to discuss her concerns for Kate. Sarah was reassured by Debbie's interest in all of Kate's strengths and her day-to-day activities at home. In

addition to voicing her general concerns about Kate's well-being in a group of children, Sarah described her specific concern about Kate's feelings of frustration and difficulties in expressing her needs, which led to crying instead of asking for help. Sarah and Debbie together devised strategies staff could use to respond to Kate's frustration while helping her express her emotions in a different way.

Sarah described candidly Kate's likes and dislikes in interactions with peers and adults. She and Debbie planned to designate one classroom teacher as Kate's "special person," who initially would respond to Kate and set up situations that would allow her to interact with a limited number of children at a time. They planned to include other children and adults in groups with Kate gradually, when Kate felt more comfortable in the center. Debbie's openness to Sarah's ideas alleviated her concerns about leaving Kate.

Debbie let Sarah know the staff's concerns about Kate's apnea monitor. The two planned for Sarah and Tom to meet with the staff to answer staff questions about hooking up the monitor, reading it, and reacting in a crisis situation. Sarah and Tom responded to staff fears and concerns and suggested that the staff become familiar with the sound of the monitor.

Kate's first day at the center was scheduled before Sarah had to return to work. As planned, Sarah and Tom brought Kate to the center and stayed for several hours, helping to involve Kate in activities and introduce her to other children. For the next few days, Sarah stayed with Kate at the center, becoming herself more familiar with the program as the staff and children got to know Kate. After Kate had attended the center for several days part-time, Sarah was ready to leave Kate for the full day. As the teacher and Sarah had planned, Sarah decided how to structure the leave-taking. (Sarah had told the classroom teacher that Kate typically cried when separated from her parents; she wanted to feel certain that the staff could comfort Kate.) Gradually, over several days, Sarah decreased the time she spent in leave-taking, and parting became easier for Kate.

The classroom teacher was careful to make frequent contact with Sarah and Tom, both formal and informal, to give them information about Kate's daily activities and to discuss the parents' questions and concerns. Not long after Kate's enrollment in the classroom program, the family's home visitor called the classroom teacher to inquire about Kate's experiences. The parents, home visitor, and classroom teacher also met together to discuss Kate's participation in the classroom.

Conclusion

As out-of-home care during the day becomes an increasingly common experience for toddlers, parents of toddlers with special needs are challenged to secure quality care and early intervention services for their children in group settings. A smooth transition from home-based to center-based programming requires careful planning and communication among the family, the home visitor, and the center-based program staff. Attention to the roles and responsibilities of each partner in the process, at every phase of the transition, can make the transition a smooth one for child, family and professionals.

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Understanding and Treating the Hyperaggressive Toddler

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More and more often, parents and caregivers are coming to professionals for help with very young children whom they describe as out-of-control, aggressive toward others, destructive of property, and extremely noncompliant with adult rules and controls. By the time toddlers are referred for mental health treatment, they are caught in a cycle of rejection in home and in day care, with adults and with other children.

Surveys of toddlers and preschoolers have found the incidence of behavior problems to be very similar to the incidence of psychiatric disorders in school-aged children (e.g., Earls, 1980, 1982; Goupil, Comeau & Chagron, 1986; Hooks, Mayes & Volkmar, 1988; Kligman, Szmulowicz, Choptiany & Sameshima, 1980; Richman, Stephenson & Tamplin, 1985; Richman, Stephenson & Graham, 1975). These studies cite aggressive acting out as the chief manifestation of problems among both younger and older children. In a preschool screening carried out by the present writers, 18 percent of children were identified by their parents as having behavior problems; fifteen percent were described as hostile and aggressive.

Even if identified early, children with conduct problems typically prove to be the most difficult to treat among children referred for mental health services, and their disorders the most intractable (Block, 1971; Campbell, 1985; Campbell, Ewing, Breaux & Szumowski, 1956; Gersten, Langner, Eisenberg, Simcha-Fegan & McCarthy, 1976; Loeberg, 1982; Olweus, 1979; Robins, 1966; Rose, Rose & Feldman, 1989). Given the number of hyperaggressive toddlers, appropriate services must be made available for toddlers with serious behavioral and emotional difficulties, and their families, as they are becoming available for young children with physical or other developmental disabilities. Practitioners who work with very young children and their families need to become aware of successful methods for identifying, assessing and treating these children. We hope that this article will be helpful in this process.

Describing toddlers with aggressive conduct problems

Although many children continue to have occasional temper tantrums in the third year of life, observers have noted that by approximately 30 months of age, children tend to substitute verbal aggression for biting, hitting, hair-pulling, throwing objects, and pushing (Hartup, 1974). Goodenough (1931) suggests that at this stage aggression becomes "somewhat less violent and more symbolic," and, when present, is now directed primarily toward the enforcers of routines and authority.

In contrast, the toddlers we describe as hyperaggressive have outbursts that are much more intense, frequent, out-of-control, and likely to be directed at others than is typical. By the time these children reach two and a half years of age, their parents and caregivers are frustrated, frantic, and angry. John, Jane, and Michael are representative of the toddlers referred for treatment and seen by the first author at children's mental health centers in Ontario.

John T. (aged 2 years, 3 months) was described by his young parents as "acting like a monster." They see him as going up and down "like a roller coaster" into endless temper tantrums, and falling apart, with kicks, loud screams, and intense anger, every time they try to discipline him. The T's are extremely concerned about John's future. Mrs. T's family have already labelled John as "the bad one." Because of his frequent and intense tantrums, which are seen as endangering other children in the group, Mr. and Mrs. T. have been asked to keep John home from day care. Both parents express feelings of "powerlessness and desperation." Their own relationship is extremely stressed by John's behavior.

Jane P. (2 years, 6 months) is described by her mother as unable to attend to any toy or task for longer than a few minutes. She refuses to obey her mother but "listens better to her new stepfather." Jane becomes extremely angry if she is in the company of other children; she cannot play cooperatively, tending to punch and bite if the children do not give her what she wants. Jane has a lot of difficulty separating from her mother. She wants to sleep in her parents' bed, becoming terrified if her mother puts her in her own bed.

Michael K. (2 years, 11 months) is the middle child in a family of three boys. Although his single mother admits that all the boys are aggressive, she describes Michael as the most difficult. Before Mrs. K. separated from her husband, he had attacked her and the boys in several violent scenes. Convicted of assault, Mr. K. is presently in jail. Michael is defiant with anyone who tries to discipline him, particularly his mother. He is aggressive toward his brothers. He has difficulty settling to any play activities and prefers to spread toys all over and to "make a mess." He has frequent outbursts in which he destroys furniture, sprays paint on walls and creates bedlam in the home.

As is the case with older children, toddlers who are extremely aggressive also tend to evidence hyperactivity, attentional difficulties and extreme impulsivity (Prinz, Connor & Wilson, 1981). Frequently, because these externalizing symptoms are so commanding of attention, the children's underlying general anxiety and apprehension of human interaction may go unnoticed. However, in the preschool screening described above, about half the children who were identified by their parents as aggressive were also seen as overanxious. In clinical terminology, they would be described as fragmented, unfocused and disorganized, as well as hostile, angry and noncompliant. It would seem that

TABLE 1
CONTROLLING AGGRESSIVE BEHAVIORS

Developmental Capacity	Growth Promoting Environment
Physiological regulation and a sense of a strong body self.	Helps the infant achieve regularity in eating, sleeping, and elimination. Provides infant with consistent caregiving to allow infant to develop a sense of predictability; uses holding, eye-to-eye contact, and sensitive interactions attuned to the infant, which encourage a sense of body boundaries and of being understood.
Understanding of consequences; making things happen.	Provides infant with learning experiences that are stimulating and not overwhelming. Assists the infant to move to the next stage of development, but does not push child forward too soon. Arranges environment for infant to have experience of success, and joins the infant in these interactions.
Secure attachment; sense of self and other as good.	Parent continues to provide warm, positive, and predictable interactions, which enable the child to develop a secure attachment. Provides positive emotionality during holding and face-to-face interactions.
Affect modulation.	Helps the child acknowledge and label a wide range of feelings. Neither withdraws from nor punishes angry outbursts, but remains calm and helps child modulate affect.
Inhibition of behavior in response to limits; increase in compliance.	Provides limit setting that is contingent and consistent. Remains calm in times of conflict and follows through with rules and structures. Limits are firm but developmentally appropriate.
Symbolization and communication.	Encourages and values the use of language and pretend play. Participates in games and helps child utilize language to express angry feelings, and assists child to elaborate play sequences.
Beginning of empathy and prosocial behavior.	Teaches child negotiation and problem solving skills, particularly before brief separations, during conflicts, and times of intense emotion. Models empathy and teaches child about others' point of view.

their sense of self is extremely fragile; under even minimal stress they are subject to fragmentation and regression into very primitive modes of affective expression (Greenspan, 1981; Lykken, 1957; Redl, 1951).

The regulation of affect and other developmental challenges of the first three years of life

To understand John, Jane, Michael and children like them, it is important to remember that in the course of normal development infants and toddlers must resolve a number of issues in order to form the basis for more complex and optimal development at later ages. During the first three years of life, children acquire the capacity to control impulses, to interact with and understand other people, and to learn from the environment. Toddlers like John, Jane and Michael have not only failed to bring their aggression under control; they have failed to develop and acquire a number of critical capacities and, as frequently revealed in their developmental histories, have resolved inadequately many of the important developmental issues of early childhood.

The following brief review of early developmental capacities and issues typically achieved in the first three years of life draws on the work of a number of writers (e.g., Greenspan, 1981; Cicchetti, Ganiban & Barnett, in press; Sander, 1962). Observing failure in their achievement can form a basis for identifying and assessing hyperaggressive toddlers.

Birth to 12 months

Capacities that are critical for subsequent development of affect regulation normally appear in the first year of life. In the first three months of life, the infant typically achieves predictable sleep-wake and feeding schedules, which constitute a basis for later self-regulatory capacity. Once a stable physiological rhythm of eating, elimination, and sleeping/waking is established, change in schedule or routine will cause tension within the system. The baby will use self-soothing mechanisms or signal a caregiver in order to return to a state of equilibrium.

The three- to six-month-old infant is typically becoming more awake and involved in the world of people and objects. Developing cognitive capacities allow the infant to have some understanding of the relation between actions and their consequences, and to begin to form mental representations or memories of people and events. Novel stimuli cause tension. Excessively frequent experiences with unfamiliar objects, people, or routines may create a state of persistent anxiety or disequilibrium in the child.

Between nine and 12 months, the infant develops attachment relationships with principal caregivers. Attachment or interactional patterns and the emotions

that accompany them continue to be laid down as memory traces, which will influence all subsequent interactions and human relationships. Infants need to begin to hold in memory attachment figures who are sufficiently warm and consistent to sustain them during periods of stress and frustration (Cassidy, 1990). Individual differences in the establishment of secure attachments to caregivers seem strongly related to children's ability to regulate affect (Bates & Bayles, 1988; Gould, 1982; Greenberg & Speltz, 1988; Main, Kaplan & Cassidy, 1985; Matas, Arend & Sroufe, 1978; Sroufe, 1983). Many aggressive toddlers cannot be sustained by the memory of their caregivers and "fall apart" when they are not physically present.

The second year of life

By the end of the second year, children typically have developed, among other critical capacities, the ability to express a full range of human emotions, at least in rudimentary form. The range by this age encompasses not only intense anger and happiness, but also the more subtle emotions of empathy, caring, jealousy, and contentment.

At the same time, the child's style of affect regulation gradually changes from one that is primarily sensory-motor to one that relies on representational capacities. These growing symbolic capacities, which include language and pretend play, are vital for the modulation of tension and anxiety. Children usually become increasingly able to label their own emotional states (Bretherton & Beeghley, 1982; Bretherton, Fritz, Zahn-Waxler & Ridgeway, 1986); and to use negotiation in times of conflict and during separation from caregivers (Cicchetti, Cummings, Greenberg & Marvin, 1990; Marvin, 1977).

During the second year of life, toddlers also gain in their ability to remember attachment figures and pleasant experiences in times of stress and separation; in their ability to inhibit behavior in response to limits; and in their capacity for prosocial and empathetic behavior (Eisenberg & Mussen, 1989; Yarrow & Waxler, 1976). All of these capacities have an impact on the ability to control aggression. Vaughn, Koop and Krakow (1984) have noted self-initiated inhibition of behavior fleetingly available to children as young as 18 months. Many two-year-olds will redirect aggressive behavior in order to stop the crying and distress their actions may have caused another child.

The third year of life

During the third year, the child's thoughts and feelings become much more integrated. The two-and-one-half-year-old child is typically able to begin to describe and control his own negativism and anger through increasingly elaborate language and symbolic play (Vygotsky, 1976). When the child becomes angry, she may still throw a brief temper tantrum, but she will usually calm quickly and express her anger in words in a more organized fashion. The well modulated child can now talk about internal states and feelings; this capacity, in turn, facilitates control over non-verbal emotional expressions.

This selective overview of early development suggests some of the intricate interaction among lines of development that is typically involved in producing an emotionally sturdy, socially competent three-year-old. As we present our model of treating aggressive toddlers and their parents later in this article, we will revisit developmental tasks in more detail.

The growth-promoting environment

Although young children acquire some important capacities through biological maturation, the human environment plays a critical role in their development, particularly in that of the more complex and adaptive components of personality development such as affect regulation (Kopp, 1982). In Table 1 we have outlined a number of caregiver behaviors that may help foster those developmental capacities in infants and toddlers that are associated with control of aggressive behavior. Clearly, many parents are failing to provide early experiences that develop children's affect regulation effectively. An understanding of the critical elements of a growth-promoting environment for very young children can provide a clear basis for preventative parent education as well as for appropriate early intervention strategies.

Providing structure, sensitive interactions and a sense of body boundaries

In order to attain the first level of self regulation or physiological homeostasis, the infant needs a caregiver's help. The "good enough" caregiver maximizes the infant's own capacity to settle down by providing a predictable pattern or routine of caregiving, sensitive responses to the infant's needs, and synchronized attunement to his signals and cues (Tronick, 1989; Tronick, Cohn & Shea, 1985). For infants who have trouble establishing early routines of eating, sleeping and eliminating because of hypersensitivities, physiological difficulties, or temperamental vulnerabilities, the caregiver's behavior is especially important. The caregiver must not ignore the baby's requests for interaction, but neither should she bombard the infant with excessive stimulation. Sensitive caregiving will help the baby not only to establish physiological regulation early on, but also to experience a sense of his own separateness from the caregiver.

Providing experiences of mastery

Infants and young children need to feel that they can "make things happen." As a caregiver responds predictably to the child's cries and other cues, the infant learns that he can affect the world. Caregivers must also be able to provide the infant and young child with learning experiences that can challenge the child, yet allow him to return when he wishes to a comfortable, already mastered level of functioning. Trad (1990) calls this interactional process "infant previewing" and sees it as essential for optimal development of learning capacities and emotional security.

Providing a positive, accepting emotional tone

Through their emotional and physical availability, parents and caregivers make the young child feel safe.

Early in their lives infants develop expectations about other people that become a foundation for later social relationships and styles of relating (Cassidy, 1986; Sroufe, 1983). The caregiver's consistent responses and positive, accepting emotional tone toward the child help him to see other people as effective, reliable, and trustworthy, even when the child is experiencing stress.

Helping the child regulate negative affect and develop positive emotions

For the development of affect regulation, a positive emotional tone between caregiver and infant is critical (Emde, 1985). The literature on social referencing in infancy shows clearly that not only do infants and young children mirror their caregivers' emotions, they also rely on caregivers' facial and vocal displays of affect to guide their own affective displays and their own understanding of the emotional meaning of events, which then guides their subsequent behavior (Campos, 1985; Klinnert, Campos, Sorce, Emde & Svejda, 1983).

Caregivers need to use positive interactions (that may range in intensity from soothing to joyful) to shift infants' negative emotional states to more positive ones, especially if anger and sadness become overwhelming. As the child gets older, the caregiver needs to be able to continue to accept the toddler's negative—and often frightening—emotions, neither withdrawing from, ignoring, nor punishing them. The caregiver's acknowledgment of the child's feelings and help in labeling them assist the child in the larger task of modulating affect (Bretherton, Fritz, Zahn-Waxler & Ridgeway, 1986).

Setting limits and encouraging compliance

When the caregiver sets limits and manages the young child's behavior appropriately, the child is likely to become increasingly compliant and able to inhibit behavior in response to rules and structures. The caregiver must notice positive behaviors and find a consistent, effective strategy to gradually eliminate aggressive acting-out and extreme non-compliance (e.g., Barkley, 1987; Forehand & McMahon, 1986; Patterson, 1976; Speltz, unp.). By providing a consistent structure, while at the same time supporting the child's growing sense of autonomy, the caregiver acts as a figure with whom the young child can identify as she gradually internalizes the rules and demands of society.

Helping the child express anger and other negative affects symbolically

Interactions with the caregiver are critical in the long and complex process by which the young child moves beyond physical acting out of aggression to more mature, symbolic modes of expression such as language and pretend play. To nurture the child's capacity for symbolization and enrich language and communication, caregivers can enlarge on brief imaginative play episodes and help sequence play ideas.

Teaching prosocial behaviors and encouraging empathy

By modelling empathetic reaction to the infant's own distress and encouraging prosocial behavior toward other children and adults, the caregiver teaches the young child to understand and feel the emotions and needs of others, and to relieve their distress. Once able to empathize with the feelings of others, the young child is more likely to refrain from or terminate aggressive behaviors that may cause pain to others (Mussen & Eisenberg, 1989; Wichert, 1989).

The circle of rejection

The image of a circle of rejection (Patterson, 1976; Patterson, 1982; Patterson, Debaryshe & Ramsay, 1989) quite accurately describes the circumstances of toddlers whose parents or caregivers refer them for treatment because they are "aggressive" or "out-of-control." Typically, the child acts out; the caregivers punish; the child feels further rejected; the child acts out again. The child's sees himself and the world as bad. His perceptions are continually reconfirmed by repeated experiences outside the home, in day care settings, and with other children (Crowell, Feldman & Ginsberg, 1988; Landy & DeV. Peters, 1990).

The experiences of the three children we introduced earlier in this article illustrate the interactions that constitute this circle of rejection. It is important to note, however, that while each child and family can be seen as caught in such a circle, the individual developmental history and family circumstances of each child influence the display of symptoms and must inform intervention.

By the time of referral, John T. was already caught up in a situation in which his parents and grandparents constantly compared him to his "good" older brother and perceived him as a "monster" and the "bad" one. Unable to see his positive behavior, Mr. and Mrs. T. tried hard to interact appropriately with him, but continually found themselves "losing it" and punishing John harshly by yelling at him or isolating him in his room for long periods. They desperately wanted to find better ways to understand and respond to him.

A developmental history revealed that John had been a colicky, hypersensitive infant since birth and that he continued to have intense needs for his mother's total attention. Although confused and feeling defeated at the time of referral, the T's seemed to be warm, caring parents who had the capacity to adopt new parenting techniques in order to provide the special care John needed.

In a poignant episode with her parents during the assessment process, Jane P. portrayed the painful rejection she frequently experienced in interactions with them. When she became aggressive and had a temper tantrum, her stepfather responded by hitting her, while her mother seemed caught between wanting to be kind to her daughter and finding the child's naughtiness intolerable. Jane seemed to be experiencing rejection from her absent natural father, from her new stepfather, and, in a particularly confusing way, from her mother.

We learned that the P's had been disciplined very differently as children (Mrs. P. permissively and Mr. P. punitively); they were confused about what discipline techniques were appropriate. Although Mrs. P. seemed to be a warm, caring mother when we met her, she told us that after she separated from her first husband she had been extremely preoccupied with her own unhappiness. She described Jane as an "easy child" up to the time her husband left and her own subsequent unhappiness and confusion began.

TABLE 2
CLINICAL VIGNETTES

Case	Developmental Failures	Failure in Interactions
John T.	(1) Establishing physiological regulation. (2) Developing sense of understanding of consequences and self efficacy. (3) Insecure attachment. (4) Failure in affect regulation. (5) Some noncompliance, but primarily during times of fragmentation. (6) Fragmented play. (7) Some signs of concern for others, but easily "loses it".	Parents are confused and exhausted trying to act appropriately with John. Admit to "losing it" and then being overindulgent. Have given up trying to get John into a predictable routine. Avoid "together" times with John, as they have become too painful.
Jane P.	(1) Failure in affect regulation. (2) Extreme noncompliance and confusion about how to behave. (3) Some ritualistic play, but difficulty using symbolic play. (4) Very little signs of empathy or concern for others.	Parents in intense conflict over discipline. Mother overindulges to compensate for father's more punitive way of dealing with behaviors. Parents' energy consumed by conflict over disciplining Jane. Step-father has cut off having "good" times with his daughter.
Michael K.	(1) Insecure attachment with mother and father. Loss of father. (2) Extreme difficulty with modulating angry outbursts. (3) Symbolic play age appropriate. Needs some help to move beyond constant violent scenes. (4) Some compliance in some situations. (5) Inability to understand point of view of others or show empathy.	Mother emotionally unavailable for much of time. Father explosive, violent and scary for Michael. Ineffectual discipline techniques and little encouragement of symbolic ways to deal with anger. Lack of demonstration of empathy or understanding towards Michael.

Mrs. K. seemed to feel powerless in the face of her son Michael's extreme anger and aggression. She told us of her fears that Michael will become violent like his father and was already worried about delinquency during adolescence. Michael acts out sullenly the part his mother seems to have assigned him. His mother ignores him until she loses her patience; then she attacks him by screaming and spanking. Soon after Michael calms down, he begins building up to another outburst.

Since Michael's earlier development was described as normal, he seems to be reacting to the loss of his father and the memory of early scenes of violence between his parents. In addition, in a pattern we have seen frequently, Michael has no adult with whom he can identify in an adaptive way: his mother is ineffectual in her relationship to him, and his father, a powerful though absent figure, is violently antisocial.

The lives of John, Jane and Michael reveal both developmental failures and disturbances in the caretaking environment which appear to have contributed to their current extreme non-compliance, anger and aggressive outbursts (see table 2). To understand the etiology of their disturbances, one can turn, among other sources, to literature on the attachment relationships of adults (Kobak & Sceery, 1988; Main, Kaplan & Cassidy, 1985; Zeanah & Barton, 1989) and on family relationships (Goldstein, Judd, Rodnick, Alkirk & Gould, 1988; Grotevant & Cooper, 1985; Sroufe & Fleeson, 1988). It is also important to remember that developmental failures in one area can lead to failure in others. For example, the child who does not understand cause and effect relationships is likely to have difficulty inhibiting behavior, showing empathy, and regulating affect. Fortunately, the reverse is also true: acquiring one new skill may help a child develop others and, simultaneously, begin to repair interactional failures. The cycle of rejection can be interrupted.

A model for treating aggressive toddlers and their parents

The treatment of children's conduct disorders has yielded disappointing results. Almost all the research to date has targeted older children and has studied behavioral cognitive approaches; any success seems to occur only with the least disturbed families (Baum & Forehand, 1981), and immediate post-treatment gains do not persist (Charlot, Parrish, Fenton & Cataldo, 1983; Kazdin, 1985). It is likely that these failures of behavioral cognitive approaches have been due to an emphasis on external symptomatology alone, to the exclusion of parental internal dynamics and the child's developmental failures (Greenberg & Speltz, 1988). Little research exists on the efficacy of treating toddlers.

The treatment strategies we propose focus on remediating developmental capacities within the child and on training caregivers to help their children reestablish an appropriate developmental course (Brinich, 1984; Eyberg & Robinson, 1982). Parents also have the opportunity during treatment to talk about their own upbringing and difficulties with affect regulation. Table 3 summarizes specific interventions designed to address particular developmental failures.

Of course any treatment approach must be based on a sensitive assessment of each child's capacities and the interaction between parent(s) and child. This can best be accomplished by observing a non-directive play session with the child and parents, and by talking with the parents about their family history and the developmental history of the child. If learning delays, sensory processing difficulties, hypersensitivities or other problems are suspected, further specialized assessment may be helpful. Such an approach will assist the therapist in identifying strengths and difficulties in the child's development and with family interaction.

We have identified eight distinct treatment strategies that can be combined as appropriate in a therapeutic approach to very aggressive toddlers and their families.

Teaching parents about development and temperament

Since many parents have little understanding of young children's development and are confused about the meaning of their child's symptoms, practitioners should use early sessions to give parents information about normal expectations for children the age of their child and about their own child's developmental strengths as well as difficulties. The therapist can also use early sessions to convey the sense that the parents and therapists can work as a team to help the child gain important capacities that the child has not yet developed, and that this approach is directly related to aspects of behavior and development that are of concern to the parents and the therapist. An explanation of individual temperamental differences in children can help parents understand their own child's uniqueness, including his or her special needs. This focus on the child's overall development helps to keep the treatment emphasis away from blaming either the child or the parents for problems, and to move treatment in a positive, productive direction.

Establishing physiological regulation and a sense of body self

For toddlers who have not gained self regulation of eating or sleeping patterns, it will be essential to help caregivers establish a structured routine for the child whether at home or in a group setting. Without limits and structures, these children frequently experience excessive anxiety. Clearly stated, regularly enforced rules and predictable, pleasant routines for meals, bedtimes and other activities can help the whole family or group function better. Fragile children may need considerable time and assistance to prepare for daily transitions, as well as the comfort of special blankets or toys to make routines, like bedtime, easier. Therapists are likely to find that some parents need considerable assistance in enforcing appropriate structures firmly, while others need to be "given permission" to be nurturing when the child is genuinely anxious. All parents need support in distinguishing the anger of noncompliance from the pain of real distress.

Developing a sense of efficacy

The aggressive toddler is often a discouraged child, who seldom experiences success. Parents are often as discouraged as the child, seeing nothing that the child does as "correct." To help parents find and acknowledge positive aspects of the toddler's behavior, the therapist may need to be quite concrete. For example, she may help them choose appropriate toys and set up relevant play environments. She may also encourage the parents to break down tasks, like cleaning up, into very small units so that they can encourage the child as he completes each step.

Therapists can also help parents anticipate the next developmental step their child is likely to make. Parents can learn to adapt their play so as to encourage and build on the child's beginning efforts to learn a new skill, whether this is to build with blocks or to express feelings with words or play.

Fostering a secure attachment

Whatever factors have led to aggressive acting-out in a toddler, we have frequently observed a singularly joyless quality in the relationships between aggressive young children and their parents. It is possible to change relationships between young children and their parents (Erickson, Sroufe & Egeland, 1985; Greenberg & Speltz, 1988), although it sometimes requires heroic efforts to enable parents and children to enjoy each other.

Encouraging parents to observe and comment (nonjudgmentally) on their child's play can be a useful technique. Actively helping parents find activities that they and their child both enjoy can be effective; very simple rhythmic games, outdoor play, and face-to-face interactional games can all be paths to re-establishing secure bonds of attachment. Working together with parents and children in the home makes it possible to take advantage of the family's resources and style of interaction.

If the child is in day care, selecting a specific caregiver to work individually with the child may help the child establish a warm, positive internal representation of that person that the child can remember in times of stress.

Achieving modulation of affect

Parents of children with aggressive conduct problems often have difficulty in modulating their own anger and, consequently, in dealing with their children's aggressive outbursts. If witnessing their child's aggression is too painful, parents may deny or ignore their child's affect or immediately devalue the child's unpleasant feelings. Two messages from the therapist may help parents to stay with the angry child, to refrain from attacking him, and to encourage the child to talk about his feelings. The parent needs to be helped to:

TABLE 3
DESIGNING INTERVENTIONS

Developmental Failure	Intervention
Lack of predictability in sleeping, eating, toileting. Lack of firm sense of own body.	(1) Helping parents establish a consistent routine for the child's eating and sleeping. (2) Encouraging parents to allow child a transitional object, such as a blanket or toy, to help sustain him/her at bedtime. (3) Encouraging games and activities to establish a sense of body boundaries, eg., rocking, imitation games; moving to music.
Lack of sense of efficacy in being able to affect world.	(1) Helping parents set up environment and choose toys to give child a sense of success. (2) Help parents notive the "positive" and learn how to effectively reward their child. (3) Help parents break down tasks, such as dressing, into small sequences and to reward small successes. (4) Teach parents about next expected developmental stage for child; help them "preview" with child.
Insecure or disorganized attachment.	(1) Encourage parents to have some positive time with their child. (2) Encourage face-to-face contact between parent and child so child can begin to internalize visual memory of parent. (3) Help parent negotiate and explain separations to child.
Failure in regulation and control of emotions.	(1) Help parent encourage child to use feeling words. (2) Encourage parent to read child's body language and verbalize feelings for child. (3) Help parent to neither withdraw from nor punish child's anger, and to "stay with child." (4) Assist parents in techniques for anger control.
Extreme noncompliance and aggressive behavior.	(1) Assist parents in establishing structures and limits. (2) Help parents agree on discipline techniques, which will be nonviolent and age appropriate. (3) Help parents with enforcing limits.
Lack of symbolic play or language delays.	(1) Ask the parents to play with child once a day for brief period. Demonstrate how to act as a "play therapist". (2) Improve parents' communication skills with child. (3) Demonstrate to parents how to expand play sequences.
Disregard of needs of others; lack of empathy.	(1) Gradually help child to negotiate and problem solve over very small issues and conflicts. (2) Teach parent to show concern for child's feelings and hurts. (3) Give child small choices and discuss the choices. (4) Teach child to delay physically acting-out and to communicate first.

• Acknowledge the child's feelings and help him or her to label and verbalize them.

• Once the child becomes upset or overwhelmed by negative feelings, help the child gradually move back to more positive feelings by defusing an immediate conflict, playing a game, or encouraging a rest period.

If the skills of verbalizing/validating negative feelings and moving back to positive ones are new ones for parents, they may need to practice them in their interactions with other adults before they can teach them to their children.

Helping parents set limits

Parents often report that they have tried "everything" to eliminate their children's negative behaviors. The therapist must be able to help parents establish age-appropriate and consistent limits. For example, it may help to work initially on eliminating one child behavior that the parents find particularly difficult. If they experience some immediate, if limited success, they may be encouraged to continue their efforts. Parents need to realize that they have choices in disciplinary strategies, but also should be given the clear message that physical punishment will only lead to an escalation of aggressive acting-out and, ultimately, to their child's enduring sense of rejection.

Encouraging symbolization and communication

Many parents of aggressive toddlers were themselves

never encouraged to play as children. Helping such parents appreciate the importance of pretend play, and communication in general, may be difficult, but the investment is essential. Therapists can show parents how to listen to their children and how to observe their nonverbal communication as well. They can also teach parents to suspend critical or intrusive comments during play sessions and other interactions. Videotaping play interactions between toddler and parent(s) and reviewing positive episodes can be an effective way of encouraging play efforts. If parents have extreme difficulty assisting the child in play, the therapist may demonstrate ways to encourage play with the toddler, with parents watching.

Teaching empathy and prosocial behavior

Parents can begin to help children understand the feelings and point of view of others at a very early stage of the infant's development, even though the child himself will not develop this capacity fully until much later. As parents become more attuned to their toddlers' feelings and begin to acknowledge them, we often observe children making significant gains in their capacity to understand the feelings of others. Parents can also teach their children negotiating skills—listening to the other person's point of view, describing their own problem to others, and, with the help of adults, deciding on a solution. Obviously, these are complex tasks for two-year-olds. With help and as their communication skills improve, many toddlers can learn to participate in joint problem solving with other children.

Helping John, Jane and Michael

As we planned and carried out treatment with John, Jane and Michael and their families, we reviewed each of the elements of our treatment model. This process allowed us to identify and encourage the positive aspects of the families' interaction, as well as to devise appropriate treatment strategies.

The length of treatment varied with each of these families. John's parents, less troubled by present conflicts and past traumatizations, needed only eight sessions to focus on John's developmental vulnerabilities and to reestablish their confidence in their own already adequate parenting skills. For Jane and Michael's families, sessions with the parents emphasized helping them improve their own capacity to modulate affect; set appropriate limits; and teach empathy and prosocial skills. Meetings over many weeks were needed to reinterpret their children's behavior and to encourage families to change their circles of rejection. Dramatic shifts were often followed by weeks of more painstaking work, as changes were internalized and new patterns of interaction established.

Notably, all three children have made dramatic improvements in gaining control of acting-out behavior and aggression. They have also learned more symbolic ways to express negative affect and to communicate feelings of anxiety, anger and sadness.

In working with the families of Jane and Michael, we discovered that as we discussed developmental issues and the elements of a growth-promoting environment, the families volunteered important memories of their own upbringing. It was essential to deal with this material as it came up. Jane's stepfather, for example, needed to share, painfully, his own experiences of abuse before he could gain control over his violent outbursts towards Jane. Similarly, Michael's mother needed considerable time to express her grief and anger at her husband's violence before she could become emotionally available to Michael in appropriate ways. Allowing parents sufficient time to discuss their own issues enabled them to make significant shifts in their relationships and their self concepts rather than merely superficial changes in behavior. A strong alliance between the therapist and the parents in each family was essential to improving their sense of efficacy and ultimately to the success of treatment.

We want to emphasize, however, that providing general information on development and ways to foster growth seemed to be an effective and non-threatening way to avoid "blaming" either child or parent and to refocus on the whole child, not just his or her aggression. As the parents gained a better understanding of development, they became better able to see strengths in their child. Our emphasis on parent-child interaction gave parents, rather than the therapist, the central role in treatment. Indeed, treatment could be seen as the reestablishment of a positive relationship between parents and child and consequently a way to begin to change negative internal representations and cognitive misattributions before they have begun to impact on behavior in school with peers and teachers.

Conclusion

Increasing numbers of children under the age of three are showing aggressive behavior so extreme and out-of-control that their alarmed caregivers are coming to mental health professionals for assistance in managing these children. Efforts to treat conduct disorders in older children, adolescents and adults have proven expensive and only minimally successful. In a society desperate to counter a rising incidence of abuse and criminal violence, we urgently need resources for research to:

- increase our understanding of the developmental pathways that lead to failures in the regulation of affect; and
- evaluate the efficacy of treatment models such as the one proposed in this article.

Children like John, Jane and Michael, along with their families, must be helped early in their development. If they are not, they will remain caught in an increasingly destructive cycle of rejection. Their problems will continue to escalate, with consequences equally harmful, if not more devastating than, the developmental failures resulting from untreated physical and cognitive disabilities. Acquiring the

capacity to regulate emotions is critical to living in society. Our society must find ways to give all children the experiences they need for optimal development. We must promote children's emotional growth and empathy as fully and as carefully as we attend to their physical strength or cognitive skills.

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NANCY P. ALEXANDER

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National Center Notes

by Eleanor S. Szanton

The demographics of the infant care crisis continue to get worse: The National Center for Health Statistics reported recently that the annual number of births in this country has jumped by 4% since the previous year—compared to a usual rise of approximately 1% per year. Though it is not entirely clear what factors account for this sudden increase in the "zero to three" population, it is a startling statistic for those who monitor child care for infants, toddlers and their families. It is likely to exacerbate the enormous pressure within the "iron triangle" of availability, affordability and quality.

We know that about ¾ of all children under age three whose mothers are in the labor force are cared for either in the child's home (33%) or in another home (41%). Yet 22 states exempt from licensing family day care homes with five children or fewer; 36 states exempt homes with three children or fewer. Fourteen states exempt child care sponsored by religious institutions. These are *legal* exemptions from oversight. Additional large numbers of children are in family day care homes which have never made themselves known to the system and remain effectively unmonitored.

Yet the costs of this care remain extraordinarily high and inequitably borne. The most recent Census Bureau Study of Child Care Arrangements shows that 25% of a working class employed mother's income, on the average, goes to child care, as opposed to 6% of a middle class family's income.

The parents of children born in the 1990's not only cannot find enough high quality child care but also are unable to choose an affordable way to be at home with their new babies. For the majority who need to work, there is no combination of tax credits, child allowances and family leave which would allow them a genuine option.

It is against this somber backdrop that we discuss the several pieces of legislation enacted in the last session of Congress. Together they promise to make some inroads on the "See no evil, hear no evil, speak no evil" approach to federal child care policy for children under age three.

Child Care and Development Block Grant and Title IV-A of the Social Security Act. After many years of activity by child advocates and others, the Congress passed the Child Care and Development Block Grant, authorizing $750 million in FY 1991 to improve the affordability, accessibility and quality of child care. The bill has been signed into law by the President. Seventy-five percent of the Grant's funds are to go to low income families as well as to activities to *improve availability and quality of care.* All providers accepting funds through this program must accept state health and safety standards. The other 25% is reserved for latch-key programs and *improving quality.* The law prioritizes support for child care services to children from low income families and to children with special needs. (These "special needs" include abused and neglected children.)

Title IV-A of the Social Security Act (the JOBS program of the Family Support Act) was amended to provide a second new source of funds to states. $1.5 billion ($300 million per year for five years) is authorized to cover the costs of day care for working families who might otherwise have to go on welfare. Another $50 million was authorized for 1992 for states to improve training and standards and monitor compliance (to be discussed below). States are required to conduct a one-time review of their existing child care standards and may impose more stringent standards on those who receive block grant funds. States will be required to make an annual report to the U.S. Secretary of Health and Human Services on use of funds, number of children in care, number of participating child care providers, caregiver salaries, and actions undertaken to improve the availability and quality of care, including state standards. The Secretary must, in turn, make an annual report to Congress. We look forward to the development of regulations by the Department of Health and Human Services.

Income supports for working poor families. Of particular interest is the authorization of a Supplemental [tax] Credit for Newborns. Low income mothers of newborns will, by 1994, be able to claim a tax credit up to $403. Furthermore, Congress expanded the Earned Income Tax Credit for low-income working families with children and set up a refundable child health care credit to offset costs of purchasing employee insurance benefits.

Head Start reauthorization. Congress has committed itself to greatly expanding Head Start and improving guality through training. Furthermore, it now allows full-day, full-year "wrap-around" child care programs in connection with Head Start. These can, of course, be satellite family day care programs. Of most interest to those particularly concerned with the well being of infants and toddlers, the bill authorized at least doubling and enriching the Parent Child Centers, a small number of which have been in place since the sixties.

Family Resource and Support Programs. Finally, the Congress passed bills authorizing funds for family resource and support programs. It authorized $30 million for a new competitive grant program to assist states with setting up networks of comprehensive, preventive family resource programs. At the same time, it authorized, under the McKinney Homeless Assistance Act, $50 million for 30 demonstration grants for family support centers to provide comprehensive services to aid families previously homeless or at risk of being homeless. These programs will require appropriations in 1992, if they are to be implemented.

These important, hard won new initiatives, together with expansions of Medicaid and Maternal and Child Health funding, immunization, Supplemental Security Income for children, activities in connection with P.L. 101-476 (formerly P.L. 99-457), The Development of

the Year 2000 Health Goals, and other housing and homeless initiatives can begin to have a cumulative impact on our nation's youngest children and their families.

Shortly after the President took office, he met with the nation's governors for an Education Summit. One of the declarations which came out of that meeting was that, "By the year 2000 every child will arrive in school healthy and ready to learn." The Congressional initiatives are important elements in that general goal. However, the goal has not been refined into a PLAN at a level which transcends separate funding streams and federal agencies.

In the meantime, those around the country who are particularly concerned with the well-being of infants and toddlers and their families have very important work to do. As states review their child care health and safety standards, as they consider whether to establish new, tighter regulations, as they consider how to allocate their "child care quality" money between training, redoing regulations to make ratios lower and group sizes smaller, increased monitoring, salaries for child care providers and wooing unlicensed family day care into the system, they will need knowledgeable advocates to suggest strategies for utilizing the funds to their fullest and best.

States will also need individuals who understand and can urge ways in which these initiatives could give impetus to each other—to be shaped into a coherent PLAN similar to one we are waiting for at the federal level.

Publications:

Infant/Toddler Caregiving: A Guide to Creating Partnerships with Families (1990)—Mary B. Lane and Sheila Signer
Infant/Toddler Caregiving: A Guide to Routines (1990)—Janet Gonzalez-Mena
Infant/Toddler Caregiving: A Guide to Setting Up Environments (1990)—J. Ronald Lally and Jay Stewart
Infant/Toddler Caregiving: A Guide to Social-Emotional Growth and Socialization (1990)—J. Ronald Lally, editor
(Bureau of Publications, Sales Unit, California Department of Education, P.O. Box 271, Sacramento, CA 95802-0271) $8.25 each, plus sales tax for California residents.

These four guides are elements of the Program for Infant/Toddler Caregivers, a multimedia training system for caregivers serving children birth to three years of age that is being developed for the Child Development Division, California Department of Education by the Center for Child and Family Studies, Far West Laboratory for Educational Research and Development. Other elements of the system include video materials and training intensives (see Conference Call, May, this issue).

Creating Partnerships with Families addresses aspects of caregiver/family relationships, including considering the family in its culture, conducting business with families, helping stressed families, and handling difficult issues, from biting to mistreatment. *Routines* describes feeding, diapering, greetings and departures, and other routines as opportunities for caregivers to build a close personal relationship with each child. Lists of appropriate and inappropriate practices are included. *Setting Up the Environment* considers group size, age, family and center care, and dividing and defining space as factors in designing settings to fit individual program needs. *Social-Emotional Growth and Socialization* includes articles by Stella Chess, Stanley Greenspan, J. Ronald Lally, Jeree Pawl, and Alice Honig and Donna Wittmer, as well as examples of appropriate and inappropriate practice.

Infants, Toddlers, and Caregivers (1989)—Janet Gonzalez-Mena and Dianne Widmeyer Eyer (Mayfield Publishing Company, 1240 Villa Street, Mountain View, California 94041) $16.95.

This book is designed to be used both in academic settings and on the job by those who train caregivers of infants and toddlers. The chapters on caregiving and play as curriculum, child development, the physical and social environment, and adult relations all illustrate a philosophy of caregiving developed by Magda Gerber, Tom Forrest, and the late Emmi Pikler. The ten principles of this philosophy are:

1. Involve infants and toddlers in things that concern them.
2. Invest in time when you are totally available to individual infants and toddlers.
3. Learn each child's unique way of communicating and teach them yours.
4. Concentrate on the "whole child."
5. Respect infants and toddlers as worthy people.
6. Be honest about your feelings around infants and toddlers.
7. Model the behavior you want to teach.
8. Recognize problems as learning opportunities, and let infants and toddlers try to solve their own difficulties.
9. Build security by teaching trust.
10. Be concerned about the quality of development in each stage.

The authors note that while the book is practical, it is not an "activity book," which they would see as useless without an underlying philosophy and focus on relationships. What infants and toddlers need, they suggest, are "attention to their physical and psychological needs; a relationship with someone they can trust; respect; a safe, healthy, and developmentally appropriate environment; chances to interact with other infants and toddlers; and freedom to explore using all their senses."

Who Knows How Safe? The Status of State Efforts to Ensure Quality Child Care (1990)—Gina C. Adams (Children's Defense Fund, 122 C Street, N.W., Washington, D.C. 20001) $5.95.

This report characterizes many of the gaps in current state child care regulatory policies as "inexcusable failures to protect the health and safety of children in child care." The report also describes the efforts that states are making to invest in and strengthen child care regulatory systems. These efforts include reducing the number of child care facilities that are exempt from minimum standards and regular inspections; strengthening health, safety and developmental requirements for regulated facilities; and strengthening monitoring and enforcement efforts to ensure compliance. In addition, a number of states are making efforts to improve program quality through salary enhancement, provider training, and involvement of parent/consumers.

In addition to state-specific illustrations throughout the text, the report includes state-by-state data in tabular form on various aspects of child care regulation. A list of state contacts includes not only officials responsible for licensing and other quality issues but also advocacy contacts.

Early Literacy (1990)—Joan Brooks McLane and Gillian Dowley McNamee (Harvard University Press, Cambridge, Massachusetts 02138) $17.95, cloth; $7.95, paper.

The development of literacy, note McLane and Dowley, consists of mastering " a complex set of attitudes, expectations, feelings, behaviors, and skills related to written language." The development of literacy does not just happen, but is described as a profoundly social process that begins in children's relationships with their immediate caretakers, and is expressed and elaborated in increasingly wider communities. Activities such as pretend play, drawing, and being read to can nurture and influence children's understanding of "what the system of written language is all about."

Parents, family members, and others introduce young children to literacy by serving as models of literate behavior, by participating in reading and writing with children, by encouraging play and fantasy, and by reading aloud. Observations of professional, inner-city, and Asian refugee families suggest that more important than access to books and writing implements themselves is how such materials are used by adults, how they are made available to children, and what messages about their use and importance are communicated.

Early Literacy is a part of the *Developing Child* series, edited by Jerome Bruner and Michael Cole. Other recent volumes include *Sisters and Brothers* by Judy Dunn and *Infancy* by Tiffany Field.

Handbook of Developmental Psychopathology (1990)—Michael Lewis and Suzanne M. Miller, editors (Plenum Publishing Corporation, 233 Spring Street, New York, NY 10013-1578) $70.00.

The editors of this volume define developmental psychopathology as "the study of the prediction of development of maladaptive behaviors and processes." The developmental perspective of the field introduces the problems of change and transformation; the psychopathological perspective introduces the concept of individual difference, and with it the variety of possible processes and outcomes.

The 63 contributors to the handbook include researchers and practitioners of psychology, psychiatry, human development and family studies, and pediatrics, among other disciplines. Sections of the volume are devoted to issues and theories of developmental psychology; to intervention; and to the behavioral, psychological, genetic and social factors involved in "undercontrolled disorders" (e.g., attention deficit and conduct disorders), "overcontrolled disorders" (e.g. anxiety, postraumatic stress, and phobias), depression, and specific and pervasive disorders.

Issues in the Developmental Approach to Mental Retardation (1990)—Robert M. Hodapp, Jacob A. Burack, and Edward Zigler, editors (Cambridge University Press, 40 West 20th Street, New York, NY 10011) $44.50.

The construction of a comprehensive developmental approach to mental retardation is difficult to accomplish, the editors of this volume suggest, because such an approach encompasses two topics that many consider to be incompatible. Developmental theorists have typically considered only nonhandicapped people when discussing the nature of developmental processes. Mental retardation researchers, on the other hand, have tended to be "indifferent" to developmental theory, viewing individuals with mental retardation as suffering from one or a few specific defects.

The contributors to this book, however, believe that, as in the study of developmental psychopathology (see above), developmental theory can usefully inform the investigation of mental retardation, and an understanding of mental retardation can illumine general developmental processes. For example, Arnold Sameroff, writing on "neo-environmental" perspectives on developmental theory, suggests that if we can understand the forces that increase the intelligence of whole societies (as has occurred during the last several generations), perhaps we can also understand the processes that will increase the intelligence of specific individuals within society. Fred Volkmar, Jacob Burack and Donald Cohen discuss the study of children with autism as a "particularly cogent" test of the hypothesis that certain aspects of psychological growth are common to all persons, and that even the most atypical behaviors and developmental patterns must be viewed within the context of normal development.

Conference Call

March, 1991

March 22-23: The *Division of Developmental and Behavioral Pediatrics, Boston City Hospital* and *Boston University School of Medicine*, will present a course in Cambridge, Massachusetts on "Clinical Problems in Primary Care." Topics addressed will include infants and toddlers, office management of common problems, and child development in a social context. Faculty will include T. Berry Brazelton, Mary Cerreto, Margot Kaplan-Sanoff, Teresa Kohlenberg, Robert Needlman, Steven Parker and Barry Zuckerman, among others. Contact Dept. of Continuing Medical Education, Boston University School of Medicine, 80 East Concord St, Boston, MA 02118, tel: (617) 638-4605.

April, 1991

April 10: The *New Interdisciplinary School* will sponsor a conference in Melville, Long Island, New York featuring Daniel Stern. His topic will be "Enhancing Parent-Child Relationships: Models of Intervention." Contact the New Interdisciplinary School, 1 Scouting Boulevard, Medford, NY 11763, tel: (516) 924-5583.

April 11-12: The *Massachusetts Early Intervention Consortium* will hold its 12th annual conference in Marlborough, Massachusetts, entitled "Innovations in Early Intervention." Keynote speaker Barbara Fields will address clinical implications for working with multiproblem families in the early intervention service delivery system. Contact Patricia Hall Pellegrino, Conference Chairperson, Pediatric Development Center, 388 Columbus Ave. Ext., Pittsfield, MA 01201, tel: (413) 499-4537.

April 18-20: The *Medical College of Ohio, Lucas County Children Services*, and the *Toledo Bar Association* will sponsor a conference in Toledo, Ohio entitled "Through the Eyes of the Child: Abused and Neglected Children and Their Families." Plenary speakers will include Richard Krugman, Kee MacFarlane, Ray Helfer, Christine Pawelski, Mary de Chesnay, David Corwin, and David Chadwick, among others. For information, contact the Office of Continuing Medical Education, Medical College of Ohio, P.O. Box 10008, Toledo, OH 43699-0008, tel: (419) 321-4237.

April 21-23: The *Michigan Association for Infant Mental Health* will hold its 15th annual conference in Ann Arbor, Michigan on the theme "Uniting to Support Infants and Families in Crisis." Speakers will include Phillip Davis, Martha Farrell Erickson, Fern Kupfer, Margaret Morgan Lawrence, and Jeree Pawl. Write or call The University of Michigan Extension Service, Department of Conferences and Institutes, 200 Hill Street, Ann Arbor, MI 48104-3297, tel: (313) 764-5305.

April 24-25: The *Family Child Learning Center* will offer a workshop in Akron, Ohio on "Early Intervention: Roles of Families and Professionals." Speakers will include Maria Hari, Rebecca Fewell, David Finn, Georgia DiGangi and Mary Beth Bruder. Contact Joan Markowski, Family Child Learning Center, 90 West Overdale Drive, Tallmadge, OH 44278, tel: (216) 633-2055.

April 25-28: *Save the Children/Child Care Support Center* will host the Fourteenth Annual Family Day Care Technical Assistance Conference in Atlanta, Georgia. Pat Ward and Jim Greenman will be keynote speakers. For further information write or call Joe Perreault, Save the Children/Child Care Support Center, 1340 Spring Street, Suite 200, Atlanta, GA 30309, tel: (404) 885-1578.

May, 1991

May 3: The *Division for Early Childhood (DEC), Council for Exceptional Children*, will sponsor a conference in Madison, Indiana on "Interaction and Play: The Scaffold for Early Intervention." Faculty will include Jeanette McCollum, Eva Thorp, Josie Thomas, and Sharon Bevins. The conference will be repeated at two additional locations later in the year. For information, contact Joan Neef, 288 Education Building, 1310 S. 6th Street, University of Illinois, Champaign, IL 61820, tel: (217) 333-0260.

May 16-18: The *Hospital for Sick Children* will sponsor a clinical workshop in Washington, D.C. entitled "Advanced Therapeutic Interventions for Infants and Children with Neuromuscular Dysfunction." Instructors will be Zahava Alon and Georgia DiGangi. Write or call Beverly Willard, The Hospital for Sick Children, 1731 Bunker Hill Rd., N.E., Washington, D.C. 20017, tel: (202) 832-4400, x 252.

May 21-24: The *Center for Child and Family Studies, Far West Laboratory*, will hold a training intensive on The Program for Infant/Toddler Caregivers, Module 1 (Social-Emotional Growth and Socialization) at Asilomar Conference Center in northern California. Faculty will include Stella Chess, Jeree Pawl, Donna Wittmer and J. Ronald Lally. Contact Carol Lou Young-Holt, Far West Laboratory, 180 Harbor Drive, Suite 112, Sausalito, CA 94965, tel: (415) 747-0276 (conference number only).

June, 1991

June 1: The *Child Development Center at Children's Hospital Oakland* will sponsor a conference in Oakland, California entitled "Special Children: Pediatric Perspectives in the 90's." Faculty will include Jack Shonkoff (special guest faculty), Marshall Klaus, Barbara Ivins, Nancy Sweet, Richard Umansky, and Kathy Vandenberg, among others. For information, contact Kim Leadon, Continuing Medical Education, Children's Hospital Oakland, 747-52nd Street, Oakland, CA 94609, tel: (415) 3021.

June 27-28: See page 12 for information about NCCIP's national technical assistance forum, "Finding and Funding Quality Infant Child Care."